

## **SECTION-BY-SECTION SUMMARY OF RULES COMMITTEE PRINT 115-58**

### **DIVISION B – FURTHER EXTENSION OF CONTINUING APPROPRIATIONS ACT, 2018**

Sec. 1001. Continues funding for the government through March 23, 2018. Includes the following new anomalies:

- Providing an additional amount to avoid delays in preparation for the 2020 Census.
- Providing operating funds for the Southeastern Power Administration which are fully offset by collections from power customers.
- Authorizing the Secretary of Energy draw down and make sales from the Strategic Petroleum Reserve fund.
- Providing the Judiciary with additional juror fees to accommodate for increased juror usage.
- Providing emergency funding to the Small Business Administration so they may continue to issue disaster loans and aid recovery in areas affected by 2017 natural disasters.

### **DIVISION C – DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2018**

Contains text of H.R. 695 as passed by the House on January 30, 2018.

### **DIVISION D – MISCELLANEOUS**

Sec. 1501. Extends authorization for one fiscal year for the Environmental Quality Incentives Program and provides authority to make funds available until expended.

### **DIVISION E – TAX MATTERS**

Sec. 1601. In the case of a corporation with assets of at least \$1 billion, the provision repeals an 8-percent increase (originally enacted in the Trade Preferences Extension Act of 2015) in the amount of the required installment of estimated tax otherwise due in July, August, or September of 2020. The next required installment (*i.e.*, the payment due in October, November, or December of 2020) is reduced accordingly.

### **DIVISION F – HEALTH PROVISIONS**

#### **Title I—Medicare Extenders and Related Policies**

#### **Subtitle A—Medicare Part A**

#### **Section 2100: Short Title**

Strengthening and Underpinning the Safety-net to Aid Individuals Needing Care Act of 2018’’ or the ‘‘SUSTAIN Care Act of 2018’’.

### **Section 2101: Extension of the Medicare-dependent hospital (MDH) program**

MDHs are small, rural hospitals with a high proportion of patients who are Medicare beneficiaries. MDHs receive special treatment, including higher payments. To be eligible for the MDH program, hospitals must have no more than 100 beds and at least 60 percent of their acute inpatient days or discharges must be for Medicare patients. Congress has extended the MDH program several times, the most recent extension included in Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), expired on October 1, 2017. This section would provide a two-year straight extension of this policy until October 1, 2019.

### **Section 2102: Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals**

Qualifying hospitals receive increased payments to account for the higher incremental costs associated with a low volume of discharges. Current thresholds to qualify for the program are set at less than 1,600 discharges and more than 25 road miles from another acute-care hospital. Congress has extended the low-volume program several times, the most recent extension included in MACRA, expired on October 1, 2017. This section would provide a two-year straight extension of this policy until October 1, 2019.

### **Section 2103: Studies relating to hospital programs paid outside of prospective systems**

This section requires the Medicare Payment Advisory Commission (MedPAC) to examine all hospital payments that are paid outside of the traditional inpatient and outpatient reimbursement systems. Specifically, the study requires a close examination of payments made under MDH and low-volume programs (described above).

### **Section 2104: Extension of home health rural add-on**

Medicare provides increased payments under the home health (HH) prospective payment system (PPS) for home health care provided to beneficiaries in rural areas. MACRA extended the 3-percent Medicare HH PPS rural add-on through December 31, 2017. This section would provide a 5-year extension of this policy with reforms until October 1, 2022. The reforms in this section include a new methodology to target the add-on payment to those areas with a population density of 6 or fewer individuals per square mile.

## **Subtitle B—Medicare Part B**

### **Section 2111: Ground ambulance services cost reporting requirement**

This section would extend the 2-percent urban, 3-percent rural, and 22.6-percent super rural ground ambulance add-on payments for five years. The section would require annual cost reporting, by adding providers and suppliers of ground ambulance suppliers as a new category. Congress has extended the ambulance add-ons several times, the most recent extension included in MACRA, expired on January 1, 2018. This section would provide a five-year extension of this policy until December 31, 2022.

### **Section 2112: Extension of work Geographic Practice Cost Indices (GPCI) floor**

Medicare payments to physicians are geographically adjusted to reflect the varying cost of delivering physician services across areas. The adjustments are made by indices, known as the Geographic Practice Cost Indices (GPCI) that reflect how each geographic area compares to the national average.

In 2003, under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress established that for three years there would be a “floor” of 1.0 on the “work” component of the formula used to determine physician payments, which meant that physician payments would not be reduced in a geographic area just because the relative cost of physician work in that area fell below the national average. Congress has extended the work GPCI floor several times since then, the most recent extension included in MACRA, expired on January 1, 2018. This section would provide a two-year straight extension of this policy until January 1, 2020.

### **Section 2113: Repeal of Medicare payment cap for therapy services; replacement with limitation to ensure appropriate therapy**

Medicare beneficiaries face a cap for all Medicare-covered outpatient therapy services. Established by the Balanced Budget Act of 1997 (BBA 97), these limits are applied to therapy services provided by nonhospital providers, to be applied separately for: (1) physical therapy (PT) services and speech-language pathology services; and (2) occupational therapy (OT) services. Congress has never let the cap go into effect for any year for all services realizing the potential harm to limiting beneficiary access to these services and has since legislated a higher cap after a series of delays to the enforcement of the cap, and instituting an exceptions process through the Centers for Medicare and Medicaid Services (CMS) for exceeding the cap if extra services are “reasonable and necessary.” In 2006, Congress established an exceptions process to allow providers and practitioners to request an exception to the therapy caps on behalf of a

beneficiary when the additional services are reasonable and necessary. MACRA extended this exceptions process through Dec. 31, 2017, and it also required the HHS Secretary to implement a targeted manual medical review process for outpatient therapy services. This section would permanently repeal the outpatient therapy caps beginning on January 1, 2018. It would continue to require that an appropriate modifier be included on claims over the current exception threshold indicating that the services are medically necessary, and it would lower the threshold for the targeted manual medical review process from \$3,700 to \$3,000.

### **Subtitle C—Miscellaneous**

#### **Section 2121: Providing continued access to Medicare Advantage special needs plans for vulnerable populations**

Special Needs Plans (SNPs) are Medicare Advantage (MA) plans that provide services for individuals with special needs. SNPs are permitted to target enrollment to one or more types of special needs individuals, including those who are: (1) institutionalized; (2) dually eligible for both Medicare and Medicaid; or (3) living with severe or disabling chronic conditions. Congress has extended SNPs several times, but the most recent extension (which was included in MACRA) expires on January 1, 2019. This section permanently reauthorizes SNPs, along with a number of reforms to D-SNPs and C-SNPs that will improve care management.

#### **Section 2122: Extension of certain MIPPA funding provisions; State health insurance assistance program reporting requirements**

Congress has extended programs for outreach, counseling and information assistance to Medicare beneficiaries several times, the most recent extension included in MACRA, expired on September 30, 2017. This section reauthorizes these programs for two years through September 30, 2019. The Agency for Community Living would also be required to post funding and other information consistent with the terms and conditions of receipt of such funding, by state and grantee organization, on its public website.

#### **Section 2123: Extension of funding for quality measure endorsement, input, and selection; reporting requirements**

HHS is required to have a contract with a consensus-based entity to carry out specified duties related to performance improvement and measurement. These duties include, among others, priority setting, measure endorsement, measure maintenance, and annual reporting to Congress. This section appropriates \$7.5 million for each of the Fiscal Years (FY) 2018 and 2019. Congress has extended the consensus-based entity several times, the most recent extension

included in MACRA, expired on October 1, 2017. This section would provide a two-year extension of this policy until September 30, 2019.

## **Title II—Additional Medicare Policies Relating to Extenders**

### **Section 2201: Home health payment reform**

This section requires the Secretary to reform the current home health payment system, beginning January 1, 2020. The Secretary is required to implement a 30-day episode for payment. This change is required to be budget neutral.

### **Section 2202: Information to satisfy documentation of Medicare eligibility for home health services**

This section allows the Secretary to utilize the medical records of home health providers, in addition to the medical records of physicians, when determining a patient is eligible for home health services.

### **Section 2203: Voluntary settlement of home health claims**

When services are submitted for payment to Medicare, those services may be denied for a number of different reasons. After a denial, providers have the right to appeal the decision. In recent years, the Medicare appeals backlog has grown at an unsustainable level and the Secretary is not able to process appeals in a timely manner. This section gives the Secretary authority to enter into a voluntary settlement with home health providers to clear some of the appeals backlog.

### **Section 2205: Extension of enforcement instruction on Medicare supervision requirements for outpatient therapeutic services in critical access and small rural hospitals**

This section prevents Medicare's enforcement of unreasonable and inflexible direct supervision rules for outpatient therapy services at Critical Access Hospitals (CAHs) and other small, rural hospitals for 2017. An annual extension bill has been passed into law since 2014.

### **Section 2206: Technical amendments to Public Law 114-10**

Congress passed MACRA in 2015, legislation that repealed the sustainable growth rate (SGR) formula. The law also reformed how Medicare pays providers, as well as consolidated and streamlined reporting systems and their corresponding legacy quality programs to make them

easier for providers to interact with and more relevant to their practice of medicine. After two years it has become clear that certain technical corrections are necessary to ensure the success of the new quality payment program (QPP), allow CMS more time to develop certain measurement tools, correct drafting errors and follow the intent of Congress to maximize the participation of providers and the transition to value based payment. This section addresses those concerns, giving CMS more flexibility to ensure participation and opportunity for success by all eligible clinicians by: (1) changing the inclusion of “items and services” to clarify the limitation to “covered professional services;” (2) allowing CMS flexibility in applying the 30 percent resource use performance score for three additional years; (3) allowing CMS three additional years to ensure a gradual and incremental transition to the performance threshold; and, (4) by making updates to the ability of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to further aid the development of physician led alternative payment models.

### **Section 2207: Revised requirements for Medicare intensive cardiac rehabilitation programs**

This section allows for updated guidelines for qualification to be a provider of intensive cardiac rehabilitation (ICR).

## **Title III—Creating High-Quality Results and Outcomes Necessary to Improve Chronic (Chronic) Care**

### **Subtitle A—Receiving High Quality Care in the Home**

#### **Section 2301: Extending the Independence at Home Demonstration Program**

The Independence at Home Medical Practice Demonstration Program (IAH), provides a home-based primary care benefit to high-need Medicare beneficiaries with multiple chronic conditions, allowing them to avoid unnecessary hospitalizations, ER visits, and nursing home use. This section would extend the demonstration, for two additional years and makes minor but important updates to the program. Currently in its fifth year, CMS has evaluated the program’s success and found it to have saved money for the program in the first and second years (year 3 data is still being analyzed). Under statute, the demonstration in total must generate savings, and any practice that does not generate savings of 5 percent faces removal from the demonstration. This extension will provide CMS with additional time to evaluate the program’s effectiveness and any changes that may be needed so that Congress can weigh the benefits of the demonstration to program savings and beneficiary care and whether the program should be changed, extended, or made permanent.

### **Section 2302: Expanding access to home dialysis therapy**

Currently, many patients receiving home dialysis treatments have hi-tech equipment in their homes that could be utilized to provide a complete monitoring of the patient by their providers. However, due to statute preventing the use of telehealth, these technologies are not fully utilized by providers under Medicare. This policy would simply allow for providers to utilize telehealth for home dialysis patients to fully monitor patients in their care.

## **Subtitle B—Expanding Innovation and Technology**

### **Section 2311: Adapting benefits to meet the needs of chronically ill Medicare Advantage enrollees**

Currently, a MA plan must offer the same benefit package to all of its enrollees. The Centers for Medicare and Medicaid Innovations (CMMI) is currently testing a model to allow greater flexibility for an MA plan to meet the needs of chronically ill enrollees. This section would expand the testing of the CMMI Value-Based Insurance Design (VBID) Model to allow an MA plan in any state to participate in the model by 2020.

### **Section 2312: Expanding supplemental benefits to meet the needs of chronically ill Medicare Advantage enrollees**

An MA plan must adhere to specific rules regarding the supplemental benefits that it can offer. This section would allow an MA plan to offer a wider array of targeted supplemental benefits to chronically ill enrollees beginning in 2020. These supplemental benefits would be required to have a reasonable expectation of improving or maintaining the health or overall function of the chronically-ill enrollee and would not be limited to primarily health related services.

### **Section 2313: Increasing convenience for Medicare Advantage enrollees through telehealth**

This section would allow an MA plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B beginning in 2020. The Secretary of HHS would be required to solicit comments on: what types of telehealth services should be considered to be additional telehealth benefits and the requirements for furnishing those benefits. If an MA plan provides access to a service via telehealth, the MA plan must also provide access to that service through an in-person visit, and the beneficiary would have the ability to decide whether or not to receive the service via telehealth.

### **Section 2314: Providing accountable care organizations (ACOs) the ability to expand the use of telehealth**

This section would apply the Next Generation ACO telehealth waiver criterion to the Medicare Shared Savings Program (MSSP) Track II (only if an ACO chooses prospective assignment and remains at two-sided risk), MSSP Track III, and two-sided risk ACO models with prospective assignment that are tested or expanded through CMMI as determined appropriate by the Secretary of HHS. This provision would: (1) eliminate the geographic component of the originating site requirement; (2) allow beneficiaries assigned to the approved MSSP and ACO programs to receive currently allowable telehealth services in the home; and, (3) 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. To be eligible for Medicare payment, the beneficiary must be located at an originating site that is either: (1) one of the approved sites listed in Section 1834(m)(4)(C)(ii) of the Social Security Act; or (2) the beneficiary's place of residence. Medicare would not provide a separate payment for the originating site fee if the service is furnished in the home.

### **Section 2315: Expanding the use of telehealth for individuals with stroke**

Currently, Medicare pays for physician services involved in stroke treatment under the Physician Fee Schedule, with the hospital being paid under the Hospital Outpatient Prospective Payment System and Inpatient Prospective Payment System. While many of these physician services are furnished on-site when the beneficiary presents symptoms of stroke at the hospital emergency department, Medicare will pay a physician, at a distant site, for consulting on a patient experiencing acute stroke symptoms via telehealth if the originating site hospital, where the beneficiary presents, is in a rural HPSA or a county outside an MSA.

This section would expand the ability of patients presenting with stroke symptoms to receive a timely consultation to determine the best course of treatment through telehealth, beginning in 2021. Specifically, it would eliminate the geographic restriction as to permit payment to a physician furnishing the telehealth consultation service in all areas of the country for the purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

## **Subtitle C—Identifying the Chronically Ill Population**

### **Section 2321: Providing flexibility for beneficiaries to be part of an ACO**

This section would amend Section 1899(c) of the Social Security Act to give ACOs in the MSSP the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. Additionally, this provision would give a beneficiary the option to voluntarily align to the MSSP ACO in which the beneficiary's main primary care provider is participating. The Secretary of HHS would establish a process by which beneficiaries are notified of their ability to



make such an election as well as the process by which they may change such election. The beneficiary would retain his or her freedom of choice to see any provider.

## **Subtitle D—Empowering Individuals and Caregivers in Care Delivery**

### **Section 2331: Eliminating barriers to care coordination under ACOs**

This section would establish the ACO Beneficiary Incentive Program. This new program would create a process that allows certain two-sided risk ACOs to make incentive payments to all assigned beneficiaries who receive qualifying primary care services. Eligible ACOs would be allowed to offer a flat payment, of up to \$20 per qualifying service, directly to the beneficiary. This program is voluntary. These ACOs would not be provided additional Medicare reimbursement to cover the primary care incentive payment costs. Permitting this option under a two-sided risk model would give these ACOs an additional tool to achieve better health outcomes for beneficiaries – as well as produce cost savings for both the ACO and the Medicare program. President Obama’s FY2017 budget contained a similar policy proposal. Additionally, this section requires HHS to conduct an evaluation of the Beneficiary Incentive Program. The report must include an analysis of the impact of this program’s implementation on expenditures and beneficiary health outcomes. A report to Congress is due no later October 1, 2023.

### **Section 2332: GAO study and report on longitudinal comprehensive care planning services under Medicare Part B**

Diagnoses of serious or life-threatening illnesses—such as Alzheimer’s disease and other dementias, cancer, and neuromuscular disease—are devastating to Medicare beneficiaries and their families. Some of these illnesses do not have a predictable disease progression, do not have an arsenal of treatment options that can be immediately deployed, and symptoms may not manifest for years. These circumstances make it imperative that a discussion between the patient and his or her provider occurs upon diagnosis.

This section would direct Government Accountability Office (GAO) to submit a report to Congress within 18 months of the date of enactment to inform the development of a payment code describing the formulation of a comprehensive plan of longitudinal care for a Medicare beneficiary diagnosed with a serious or life-threatening illness. Specifically, GAO would identify the extent to which such a comprehensive longitudinal care planning service is provided to beneficiaries, whether there would be any duplication in payment for such service with billing codes for which Medicare current pays, and barriers to hospitals, skilled nursing facilities, hospice programs, home health agencies, and other providers working with a Medicare beneficiary to engage in the care planning process. It would also identify any barriers to providers accessing the care plan and options for promoting adherence to it. In addition, GAO would assess the need to develop quality metrics related to care planning, the characteristics of

Medicare beneficiaries who would be most appropriate to receive longitudinal planning services, and the providers best suited to furnish the service as a part of a multi-disciplinary team.

### **Subtitle E—Other Policies to Improve Care for the Chronically Ill**

#### **Section 2341: GAO study and report on improving medication synchronization**

Individuals with chronic diseases often take multiple prescriptions that are prescribed by different clinicians. Because most prescriptions have a standard length (*i.e.*, 30-days) and are prescribed on different days, the individual is required to pick up prescriptions at various times during the month. Alignment of dispensing could improve medication adherence by individuals living with chronic diseases. This section would direct the Government Accountability Office (GAO) to submit a report to Congress within 18 months of the date of enactment that would provide information on the prevalence and effectiveness of Medicare and other payer medication synchronization programs. Specifically, GAO would identify common characteristics of programs and assess their impact on medication adherence, patient outcomes, and patient satisfaction. GAO would also assess the extent to which Medicare rules support medication synchronization and whether there are barriers to such programs in Medicare.

#### **Section 2342: GAO study and report on impact of obesity drugs on patient health and spending**

Historically, Medicare Part D has not covered drugs used for weight loss or gain, or for cosmetic purposes. Some MA prescription drug plans (MA-PDs) are permitted to cover these drugs as a supplemental benefit. This section would direct the GAO to submit a report to Congress within 18 months of the date of enactment that would provide information on the impact of the use of obesity drugs on patient health and spending. Specifically, GAO would look at obesity drug utilization in Medicare and other payer programs, identify physician prescribing attitudes, assess drug adherence, and maintain weight loss. GAO would also identify the impact of obesity drugs on patient health outcomes, on other services furnished, and health spending.

#### **Section 2343: HHS study and report on long-term risk factors for chronic conditions among Medicare beneficiaries**

This section would require the Secretary of HHS to submit a report to Congress within 18 months of the date of enactment that would evaluate long-term cost drivers to Medicare, including obesity, tobacco use, mental health conditions, and other factors that may contribute to the deterioration of health conditions among individuals with chronic conditions. The study would include barriers to collecting and analyzing the information needed to conduct this evaluation and make legislative and regulatory recommendations for removing such barriers.

## **Title IV—Medicare Part B Miscellaneous Policies**

### **Subtitle A—Medicare Part B Improvement Act**

#### **Section 2401: Home infusion therapy services temporary transitional payment**

The 21<sup>st</sup> Century Cures Act (Cures): (1) changed the way Medicare pays for home infusion services beginning in 2017; and (2) created a new Medicare benefit for home infusion education and services provided by clinicians delivering infusion to patients in their homes beginning in 2021. Since the payment change began in 2017 and the new benefit begins in 2021, beneficiaries could experience home infusion access issues during the four years between the change in payment policy and the new home infusion nursing benefit. This section would address this gap by creating a temporary transition service and education Medicare payment for home infusion beginning in 2019. This section would set the payment at the base code plus three additional units.

#### **Section 2402: Orthotist's and prosthetist's clinical notes as part of the patient's medical record**

Medicare pays for orthotics and prosthetics for beneficiaries who medically need those items. Medicare's claims review process to prevent fraud and abuse in certain cases has led to payment denials for medically necessary orthotics or prosthetics as a result of insufficient evidence and incomplete medical record notes to document medical necessity. Currently, some suppliers are experiencing a delay in payment for prosthetics already paid for and supplied to Medicare beneficiaries. This section would allow additional information provided by prosthetists and orthotists, who evaluate and fit the beneficiary for the orthotics and prosthetics, to be considered by Medicare to support documentation of medical necessity for orthotics and prosthetics.

#### **Section 2403: Independent accreditation for dialysis facilities and assurance of high quality surveys**

Facilities that provide care for Medicare beneficiaries must satisfactorily complete both a state survey and certification process as well as the Medicare accreditation process in order to participate in the Medicare program. Some providers may use an outside agency to survey and accredit their facility for Medicare participation, however this avenue is not available to dialysis facilities. This may result in access issues for end-stage renal disease (ESRD) patients, in areas where certification and accreditation does not keep pace with companies' ability to construct facilities. This section would allow dialysis providers to seek outside accreditation, from organizations approved by Medicare, in order to be able to bill Medicare for ESRD services.

## **Section 2404: Modernizing the application of the Stark rule under Medicare**

The “Stark” physician self-referral laws are meant to prevent financial interests from interfering with clinical decisions. The Stark laws prohibit physicians from referring Medicare beneficiaries to facilities in which they (or a close family member) have a financial stake and by prohibiting that facility for billing for Medicare services performed as a result of such a referral. Violations of Stark Law can range from unknowing to willful. CMS recently changed Stark law regulations relating to when leases were in violation of the Stark laws and when signatures were required to document the terms of legal arrangements. This section codifies the changes CMS made.

### **Subtitle B—Additional Provisions**

## **Section 2411: Making permanent the removal of the rental cap for durable medical equipment under Medicare with respect to speech generating devices**

This section would make coverage of speech generating devices under “routinely purchased durable medical equipment” permanent under the Medicare program. Previously, under rules issued by CMS, speech-generating devices, which are uniquely configured for each eligible beneficiary, were categorized and covered under a capped rental payment. However, if the beneficiary entered a nursing home, hospital, or hospice, payment ended, which limited access to the device. Congress responded in 2015 by passing the Steve Gleason Act, which removed speech-generating devices from the capped rental categorization for three years. This section would remove the 2018 sunset in current law and this payment category change would be made permanent.

## **Section 2412: Increased civil and criminal penalties and increased sentences for Federal health care program fraud and abuse**

Under this section both civil and criminal penalties would be updated in the Medicare program for those found to have defrauded the Medicare program and beneficiaries. Many of these penalties were last updated 20 years ago. This section would modernize these penalties.

## **Section 2413: Reducing the volume of future EHR-related significant hardship requests**

The Health Information Technology for Economic and Clinical Health (HITECH) Act is amended in order to remove a requirement that requires the Secretary of HHS to continue to make meaningful use standards more stringent over time. While the meaningful use program has been very successful in driving adoption of electronic health records (EHRs), many providers have struggled to meet the requirements of meaningful use. As the Secretary of HHS is mandated

to continue to raise the standards overtime, more and more providers are likely to fall behind. When this happens, providers will often seek a hardship waiver to acknowledge they could not meet the increased standards. This increases the burden further on HHS to process an ever-increasing number of hardship requests. The bill simply removes the mandate that meaningful use standards become more stringent over time and allows the Department to be more deliberative in such evaluations.

#### **Section 2414: Coverage of certain DNA specimen provenance assay tests under Medicare**

This section would provide for coverage of DNA Specimen Provenance Assay (DPSA) testing. Prostate cancer is diagnosed with a 10 to 12 needle biopsy samples to detect for cancerous cells, a protocol that became the clinical standard in 2010 and improved the detection rates of prostate cancer. However, despite rigorous lab protocols, a high rate (2.5 percent) of specimen provenance complications (SPCs) occur, where a test result is contaminated with tissue other than the patient's. As a result, approximately 1.28 percent of positive tests are in fact cancer free. DPSA is a diagnostic tool that can address the chances of a false diagnosis, preventing unnecessary and costly treatment protocols. DPSA compares the DNA of the patient to the DNA of the tissue sample tested for cancer. Currently, this test is not covered under the Medicare payment program due to its classification as "quality assurance" rather than a diagnostic test even though it is often covered by private insurance. This section would provide for five years of coverage under the Medicare program and a review of the policy's impact on identifying false positive results and aiding beneficiaries in avoiding unnecessary surgery and treatment.

#### **Section 2415: Strengthening rules in case of competition for diabetic testing strips**

This section addresses several issues beneficiaries face under the competitive bidding program regarding Diabetes Test Strips (DTS). Many of these issues stem from how CMS has enforced certain beneficiary protections. The competitive bidding program has several beneficiary protections that the legislation seeks to place into statute to ensure proper oversight and enforcement of these protections. For example, evidence has been presented that the 50 Percent Rule – established by Congress to ensure suppliers make available at least 50 percent of all types of DTS on the market before enactment of the competitive bidding program – has not been fully enforced by CMS. The legislation would codify these protections and provide enhanced reporting that will aid Congress and CMS in ensuring beneficiaries are receiving the diabetic testing supplies they need to manage their condition.

### **Title V – Public Health Extenders**

#### **Section 2501: Extension for community health centers, the National Health Service Corps, and teaching health centers that operate GME programs**

This section extends the funding for Community Health Centers for two years and implements technical and programmatic changes that improve the health centers' ability to function in the modern health care landscape. Combined with funding provided in the December Continuing Resolution (H.R. 1370), Community Health Centers will receive \$3.6 billion for each of FY2018 and FY2019. Section 501 also extends for two years, the funding for the National Health Service Corps and the Teaching Health Center Graduate Medical Education Program. Combined with funding provided in the Disaster Tax Relief and Airport and Airway Extension Act (H.R. 3823) and H.R. 1370, for each of FY2018 and FY2019, the National Health Service Corps will receive \$310 million and the Teaching Health Center Graduate Medical Education Program will receive \$126.5 million.

**Section 2502: Extension for special diabetes programs**

This section extends the funding for Special Diabetes Program for Type 1 Diabetes and the Special Diabetes Program for Indians for two years. Combined with funding provided in H.R. 3823 and H.R. 1370, each of these programs will receive \$150 million a year.

**Section 2503: Extension for family-to-family health information centers**

This section extends the Family-to-Family Health Information Center program for two years at \$6 million a year. In addition, this Section establishes Family-to-Family Health Information Centers in the territories and for the Indian tribes.

**Section 2504: Extension for sexual risk avoidance education**

This section extends the funding for the Sexual Risk Avoidance Education Program (formerly known as the Abstinence Education Program) for two years at \$75 million a year. This Section reforms the program by requiring data collection on funded activities, requiring the Secretary of Health and Human Services to conduct national evaluations of the education funded through the program, and by allowing unused funds to be distributed through competitive grant process.

**Section 2505: Extension for personal responsibility education**

This section extends the funding for Personal Responsibility Education Program for two years at \$75 million a year.

**Title VI: Child and Family Services and Support**

**Family First Prevention Services Act, Social Impact Partnerships, and Related Payfors**

**Subtitle A: Family First Prevention Services Act**

**Section 2601: Short title**

This title shall be cited as the “Family First Prevention Services Act.”

## **CHAPTER 1—INVESTING IN PREVENTION AND FAMILY SERVICES**

### **Section 2611: Purpose.**

The purpose of this title is to enable states to use federal Title IV-E and Title IV-B funds to enhance their support to children and families and prevent foster care placements.

## **SUBCHAPTER A—PREVENTION ACTIVITIES UNDER TITLE IV–E**

### **Section 2621: Foster care prevention services and programs.**

Would give states, territories, and tribes the option to receive federal Title IV-E funding for a part of their cost of providing services directly related to preventing the need for children to enter foster care or for their safety, permanency or well-being. This funding would be available for a maximum of 12 months to provide – (1) mental health and substance abuse prevention and treatment services (offered by qualified clinicians) and (2) in-home parent skill- based programs, including parenting skills training, parent education, and individual and family counseling. Title IV-E services and programs would be available for eligible children and their parents or kin caregivers. No income test would apply. The term would include a child who is at risk of entering foster care due to disruption or dissolution of an adoption or guardianship arrangement.

A child would be eligible for Title IV-E foster care prevention services or programs if – (1) the state determines the child is at imminent risk of entering (or re-entering) foster care, but that he or she can remain safely at home (or with kin) so long as Title IV-E prevention services or programs are provided; or (2) the child is a pregnant or parenting youth in foster care.

In addition to meeting the criteria applicable to all categories, the following criteria apply to specific evidence-level categories:

- For a “promising practice,” the finding of improved outcomes must be based on at least one study that used some form of control group (e.g., wait list study, placebo group) to determine effect.
- For a “supported practice,” the finding of improved outcomes must be based on the results of at least one study that used a random control or quasi-experimental trial to determine effect. Additionally that study must have been carried out in a usual care or practice setting and it must have found a sustained effect of the practice (for at least 6 months beyond the end of treatment).
- For a “well-supported practice,” the finding of improved outcomes must be based on the results of at least two studies that used a random control or quasi-experimental trial to determine outcomes. These studies must have been carried out in a usual care or practice

setting and at least one of them must have found a sustained effect of the practice (for at least one year beyond the end of treatment).

**Section 2622: Foster care maintenance payments for children with parents in a licensed residential family-based treatment facility for substance abuse.**

Would permit Title IV-E foster care maintenance payment support, for up to 12 months for a child in foster care who is placed with a parent in a licensed residential family-based treatment facility. While the child must have been formally placed in foster care, no income test would apply for purposes of these time-limited foster care maintenance payments.

**Section 2623: Title IV–E payments for evidence-based kinship navigator programs.**

Would permit federal funding (i.e., 50% of a Title IV-E agency’s total cost) for the support of kinship navigator programs under the Title IV-E program, provided the program:

- met the requirements for kinship navigators established under the now defunct Family Connection Grant program; and
- was operated in accordance with “promising,” “supported,” or “well-supported” practices (as defined for purposes of the Title IV-E foster care prevention component).

Federal support would be available for these kinship navigator programs without regard to whether the child being cared for by kin is in foster care, or meets the income or other Title IV-E eligibility criteria.

**SUBCHAPTER B—ENHANCED SUPPORT UNDER TITLE IV–B**

**Section 2631: Elimination of time limit for family reunification services while in foster care and permitting time-limited family reunification services when a child returns home from foster care.**

Would rename “time-limited family reunification” services as “family reunification services.” Services could be used for any child in foster care (including parents/caregivers), regardless of the amount of time the child has been in care. Would further allow this funding to be used for services provided after a child and his/her parent(s) have been reunited, but only during the 15-month period that begins on the date the child returns home.

**Section 2632: Reducing bureaucracy and unnecessary delays when placing children in homes across State lines.**

No later than October 1, 2027, would require each state, territory, or tribe operating a Title IV-E plan to include use of an electronic interstate case processing system as part of its procedures for timely placement of children across state lines.



**Section 2633: Enhancements to grants to improve well-being of families affected by substance abuse.**

Regional Partnership Grants (RPGs): Would change this section heading to include the goal of “implementing Title IV-E prevention service” and to mention improving outcomes specifically for children and families affected by heroin and opioid abuse, along with other substance abuse. Would additionally explicitly permit partnerships that operate on a statewide basis. Along with the state child welfare agency, would additionally require every partnership to include the state agency that administers the federal substance abuse prevention and treatment block grant. Would further add that if the partnership includes a tribe or tribal consortium and it intends to serve children in out-of-home placement, it may include tribal court entities in place of other judicial representatives. Would require HHS to make such grants to regional partnerships for each of FY2017-FY2021.

Would require that any grant made to a regional partnership be done in two phases – planning and implementation. Would lower the minimum annual award to \$250,000 generally, with the further stipulation that total funding awarded for the planning phase (which may extend for maximum of two years) must not exceed \$250,000. Otherwise maintains the maximum annual grant award of \$1,000,000 along with the limits on duration of the grant. Would revise the regional partnership grant application requirements to ensure that each partnership sets goals and outcomes that focus on improving the well-being of families as a whole (children and parents), including successful substance abuse treatment and recovery for parents.

Would further require applicants to describe how they intend to sustain the partnership’s work after the end of RPG funding, including through use of Title IV-E prevention services. Would add that, when considering awarding an RPG, HHS would need to consider if the applicant partnership has a track record of successful collaboration among child welfare, substance abuse disorder treatment, and mental health agencies.

**SUBCHAPTER C—MISCELLANEOUS**

**Section 2641: Reviewing and improving licensing standards for placement in a relative foster family home.**

Would require HHS to identify reputable model standards for licensing foster family homes not later than October 1, 2018. No later than April 1, 2019 each Title IV-E agency would be required to submit information to HHS on whether its own licensing standards are fully consistent with the model standards identified by HHS, and, if not, why this inconsistency is appropriate for the state, territory, or tribe.

**Section 2642: Development of a statewide plan to prevent child abuse and neglect fatalities.**

Would revise the current requirement to provide that a state must describe how it gathers information on child maltreatment deaths, including from all relevant entities in the state. Would additionally require the state to describe how it is developing and implementing a comprehensive statewide plan to prevent child maltreatment deaths that involves public health and law enforcement agencies, the courts, and other relevant public and private agency partners in the state.

**Section 2643: Modernizing the title and purpose of title IV-E.**

Would change the formal heading of Title IV-E to “Federal Payments for Foster Care, Prevention, and Permanency,” [to reflect the authorization of Title IV-E prevention services and programs, proposed in this bill, as well as the multiple forms of permanency support currently available under Title IV-E (i.e., adoption assistance and kinship guardianship assistance)].

Consistent with these changes, would amend the purposes of the funding authority to include the currently authorized kinship guardianship assistance and to add the foster care prevention services, programs and assistance that would be authorized in this bill.

**Section 2644: Effective dates.**

The general effective date for these provisions would be October 1, 2018 (first day of FY2019).

**CHAPTER 2—ENSURING THE NECESSITY OF A PLACEMENT THAT IS NOT IN A FOSTER FAMILY HOME**

**Section 2651: Limitation on Federal financial participation for placements that are not in foster family homes.**

Title IV-E foster care maintenance payment support would continue to be available without time limit for an otherwise eligible child placed in a foster family home. For a child placed in a non-foster family home setting, this Title IV-E support would only be available for two weeks unless the placement setting is one of the following:

- a “qualified residential treatment program” (QRTP), provided additional requirements are met;
- a setting specializing in services for prenatal, post-partum, or parenting supports for youth;
- a supervised independent living setting (provided the child is 18 years of age or older);
- a residential and support services for children or youth found to be victims of sex trafficking, or at risk of becoming such a victim; or

- a licensed residential family-based treatment center for substance abuse (provided the child is placed there with a parent who is receiving treatment).

For an otherwise eligible child placed in a QRTP, Title IV-E foster care maintenance support may only be available if a trained professional or licensed clinician determines the program's appropriateness for the child within 30 days of the placement. If that assessment finds that the program is not an appropriate placement for the child, or a court review disapproves of the placement, or the child is found ready to move to a family setting (including biological, relative/kin, adoptive, or foster), Title IV-E foster care maintenance payments would remain available for the shorter of 30 days from the date of that determination, or the time it takes a child to make a transition to a new setting. Would clarify that Title IV-E administrative support remains available for any child who is ineligible for Title IV-E foster care maintenance payments solely because of the limitations added by this bill (with regard to placement in a non-foster family home setting).

Under Title IV-E, a "qualified residential treatment program" means a program that meets all the following requirements:

- Has a trauma-informed treatment model designed to address the clinical or other needs of children with serious emotional or behavioral disorders or disturbances, and is able to provide the treatment identified as necessary for a child placed in the program.
- Has a registered or licensed nursing and other licensed clinical staff onsite, consistent with the QRTP's treatment model.
- Facilitates outreach to the child's family members and their participation in the child's treatment program to the extent appropriate and in the child's best interest, documents how this is done (and how sibling connections are maintained), and maintains contact information for biological family and fictive kin of the child.
- Provides discharge planning and family-based aftercare supports for at least six months after the child is discharged and continues to integrate family members in the treatment program, as appropriate during this aftercare.
- Is licensed in accordance with the state standards for child-care institutions providing foster care.
- Is accredited by any of the following agencies: the Council on Accreditation (COA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); the Commission on Accreditation of Rehabilitative Facilities (CARF); and any other independent, not-for-profit accrediting organization approved by the HHS.

Additionally stipulates that the staffing requirements for a QRTP do not require the program to directly employ nursing and behavioral staff.

Would require a Title IV-E agency (whether state, territorial, or tribal) to certify that it will not enact or advance policies or practices that lead to a significant increase in the number of children placed in juvenile justice settings as a response to the limitations added by this bill on Title IV-E support for foster children placed in non-foster family home settings.

Would require the U.S. Government Accountability Office (GAO) to evaluate any impact on juvenile justice systems that results from the limits included in this bill on federal Title IV-E support for children placed in non-foster family home settings.

**Section 2652: Assessment and documentation of the need for placement in a qualified residential treatment program.**

For any child placed in a “qualified residential treatment program,” would require the Title IV-E agency to have additional case review procedures that (1) provide for a qualified individual to assess the child’s placement in the QRTP within 30 days of the placement; (2) ensure the child has a “family and permanency team;” (3) provide for court review of child’s placement in a QRTP within 60 days of the placement; (4) ensure regular and ongoing review of the appropriateness of the QRTP placement for the child; and (5) include additional placement review measures for children with longer stays in a QRTP.

**Section 2653: Protocols to prevent inappropriate diagnoses.**

Would require states, territories and tribes to include in their health oversight plan the jurisdictions’ established procedures to ensure children are not placed in a non-family setting based on inappropriate diagnoses of mental illness, behavioral disorders, medically fragile conditions, or developmental disabilities.

**Section 2654: Additional data and reports regarding children placed in a setting that is not a foster family home.**

Would rewrite this reporting requirement to maintain current requirements while listing more types of non-foster family home settings for which specific information must be included. Would also require information on the gender and race/ethnicity of children placed in these settings, and whether the non-foster family home is the first placement setting for the child or, if not, the number and type of previous placement settings.

**Section 2655: Criminal records checks and checks of child abuse and neglect registries for adults working in child-care institutions and other group care settings.**

Would require states to have provisions to conduct criminal history and child abuse and neglect registry checks on any adult working in a child care institution, including group homes, residential treatment centers, shelters, or other congregate care settings.

Generally, these checks must follow the same procedures as those now required in the law for prospective foster or adoptive parents. However, a state may use alternative criminal history and child abuse registry checks for adults working in child care institutions if the state reports the alternative methods it uses to HHS, (along with why using the procedures now in law for prospective foster or adoptive parents is not appropriate for the state).

**Section 2656: Effective dates; application to waivers.**

Provisions limiting federal Title IV-E foster care maintenance payment support for children in non-foster family home settings, including related definitions, assessment procedures and other requirements would be effective on the first day of FY2020 (October 1, 2019). Additionally, the required Title IV-E agency certification (related to policies that might impact the juvenile justice system) would also be effective as of FY2020 (October 1, 2019).

Any state (including DC), and any territory or tribe with an approved Title IV-E plan, could request a delay in the effective date of these provisions and HHS would be required to grant such a delay for that jurisdiction (in the amount of time requested, but not more than two years (i.e., delay could be in place until the first day of FY2022). Would make the Title IV-E state plan requirement concerning background checks of adults working at child care institutions effective with FY2019 (October 1, 2018).

**CHAPTER 3—CONTINUING SUPPORT FOR CHILD AND FAMILY SERVICES**

**Section 2661: Supporting and retaining foster families for children.**

Would amend the definition of family support services to include services designed to support and retain foster families so they can provide quality family-based settings for children in foster care. Would independently appropriate \$8 million in FY2018 for HHS to make competitive grants to states or tribes to support recruitment and retention of high-quality foster families (without regard to Title IV-E eligibility status of children for whom they will care).

The grants would be intended to increase the capacity of a grantee to place more children in family settings and would need to focus on states or tribes with the highest percentage of children in non- family settings. Funding appropriated in FY2018 would remain available for five years (through FY2022).

**Section 2662: Extension of child and family services programs.**

Extension of Funding Authority for the Stephanie Tubbs Jones Child Welfare Services (CWS) Program: Would extend this same annual level of discretionary funding authority for the CWS program in each of FY2017-FY2021.

Extension of Funding Authorities for Promoting Safe and Stable Families (PSSF) program: Would extend this same annual level of mandatory funding authority (\$345 million) for the PSSF program in each of FY2017- FY2021 and the same annual level of discretionary funding authority (\$200 million) for the PSSF program in each of the same five years. Would require HHS to continue these same funding reservations out of the mandatory funding provided for the Promoting Safe and Stable Families program for each of FY2017-FY2021 (i.e., \$20 million in each of those years for Monthly Caseworker Visit grants and \$20 million in each of those years for Regional Partnership Grants).

Extension of Highest State Court Entitlement to Court Improvement Program (CIP) Funds: Would extend the entitlement of eligible state highest courts to CIP grant funding through each of FY2017-FY2021.

**Section 2663: Improvements to the John H. Chafee Foster Care Independence Program and related provisions.**

Would change the name to the John H. Chafee Foster Care Program for Successful Transition to Adulthood. Would permit eligible states to serve youth who have aged out of care and are not yet 23 years of age, provided these states certify that they will use CFCIP funds to serve youth up to this age.

Would change the target population for each of these CFCIP purposes from youth who are expected to age out of foster care (current law) to focus instead on youth who experience foster care at age 14 or older. Would also make some other adjustments to the purposes. Services to youth who experience care at age 14 or older would be intended to help them transition to adulthood. They would continue to address educational attainment (secondary and post-secondary); vocational training, career exploration and job placement and retention; preventive health activities; daily living skills (such as financial literacy training and driving instruction), and connections with caring adults (versus “mentors” and “dedicated adults,” as currently in law).

Would permit eligible states to provide assistance to youth who have aged out of care and are not yet 23 years of age. A state would only be permitted to certify that it serves such youth up to age 23 if the state has elected to extend federal Title IV-E foster care to children up to age 21, or the

HHS Secretary determines that the state provides comparable assistance with state or other non-Title IV-E funds.

Would permit HHS to reallocate funds that are not spent within the two-year period to states and tribes that apply for the funding. These funds would be redistributed among the states and tribes that apply for any unused funds, provided HHS determined the state or tribe would use the funds according to the program purposes. The amount each state or tribe would receive would be based on the share of children in foster care among the states and tribes that successfully applied for the unused funds.

Would require states to provide any youth who is aging out of foster care (on his or her 18th or later birthday as chosen by the state) with official documentation necessary to prove the child was in foster care.

#### **CHAPTER 4—CONTINUING INCENTIVES TO STATES TO PROMOTE ADOPTION AND LEGAL GUARDIANSHIP**

##### **Section 2665: Reauthorizing adoption and legal guardianship incentive programs.**

Would continue for five fiscal years (FY2016-FY2020) state's eligibility to earn incentive payments and would extend annual discretionary funding authority, at the current law annual level of \$43 million, for each of five fiscal years (FY2017-FY2021). Additionally, would permit funds appropriated under this authority to remain available until expended, but not later than FY2021.

#### **CHAPTER 5—TECHNICAL CORRECTIONS**

##### **Section 2667: Technical corrections to data exchange standards to improve program coordination.**

Would rewrite these provisions to require HHS, in consultation with an interagency work group established by the OMB, and considering state government perspectives, to develop regulations concerning the categories of information that state child welfare agencies must be able to exchange with another state agency as well as federal reporting and data exchange required under Title IV- B and Title IV-E. The HHS Secretary would need to issue a proposed rule no later than two years (24 months) after enactment of this bill that identifies federally required data exchanges and specifies state implementation options.

##### **Section 2668: Technical corrections to State requirement to address the developmental needs of young children.**

Would clarify that a state must describe in its Title IV-B plan what it is doing to address the developmental needs of all vulnerable children under 5 years of age who receive benefits or services under the Title IV-B programs or the Title IV-E foster care and permanency program (not just children in foster care).

## **CHAPTER 6—ENSURING STATES REINVEST SAVINGS RESULTING FROM INCREASE IN ADOPTION ASSISTANCE**

### **Section 2669: Delay of adoption assistance phase-in.**

For certain special needs children who do not reach their second birthday in the fiscal year their adoption assistance agreement is signed, would require use of an income test for an additional six and a half years, to determine Title IV-E adoption assistance eligibility. Specifically, beginning on January 1, 2018 and through June 30, 2024, the income test would need to be applied for any child who is under the age of two when the adoption assistance agreement is signed, provided the child will not reach his/her second birthday before the last day of the fiscal year in which that agreement is signed. As of July 1, 2024 no income test would be used for purposes of determining a child's eligibility for Title IV-E adoption assistance, regardless of the child's age. Would make this provision effective with January 1, 2018.

### **Section 2670: GAO study and report on State reinvestment of savings resulting from increase in adoption assistance.**

Would require the GAO to look at whether states are complying with the requirement to reinvest in child welfare activities any savings resulting from phasing out the income eligibility requirements for federal Title IV-E adoption assistance. The GAO would be required to submit a report with its findings, including any recommendations to ensure compliance with the law, to the House Ways and Means and Senate Finance committees.

## **Subtitle C—Supporting Social Impact Partnerships to Pay for Results**

### **Section 2681: Supporting social impact partnerships to pay for results.**

Would provide up to \$92 million for the federal government to pay for outcomes under a social impact partnership. Social impact partnerships are a funding structure where state and local governments raise funds and pay for a social service, then be repaid by the federal government only if a rigorous, independent evaluation showed the service achieved the intended result. If the independent evaluator determined the outcome was achieved, the federal government would pay the state or local government. If not, the federal government would pay nothing.

## **Subtitle D—Modernizing Child Support Enforcement Fees**



**Section 2691: Modernizing child support enforcement fees.**

Would raise the annual fee for CSE services to \$35, and increase the amount of child support that must be collected in order for a case to be subject to the fee to \$550. If states opt to retain the fee from the child support collected for a case, they would not be permitted to do so from the first \$550 collected. Would be effective as of the first day of the fiscal year beginning on or after the date of this bill's enactment. Would allow delay for states that require legislation.

**Subtitle E—Increasing Efficiency of Prison Data Reporting**

**Section 2699: Increasing efficiency of prison data reporting.**

Would provide that the \$400 incentive payment authorized under this program is available only if the report is made within 15 days of the individual's confinement and that a \$200 incentive would be available if the information was reported after 15 but before 90 days. Would apply this change in payment amount to any incentive payment made by SSA (with specific regard to confinement of SSI recipients) that is on or after 6 months of the date of enactment.

**Title VIII—Offsets**

**Section 2701: Payment for early discharges to hospice care**

This section adds hospice, as a setting of care, to the existing post-acute care transfer policy. Under the policy, hospitals would be paid less when the hospital transfers a patient to hospice, if that patient had a short length of stay in the hospital. The policy only applies in those cases where the patient falls into one of the top ten reimbursed hospital stays. The policy would begin on October 1, 2023.

**Section 2702: Home health market basket reduction**

This section would require the FY2020 market basket update for home health agencies to be 1.4 percent. In absence of this section, the home health market basket would be higher.

**Section 2703: Reduction for non-emergency ESRD ambulance transports**

This section would increase the current law payment reduction for non-emergency dialysis ambulance transports to 23-percent.

**Section 2704: Extension of target for relative value adjustments for misvalued services and transitional payment rules for certain radiation therapy services under the physician fee schedule**

In 2010 Congress mandated that CMS start developing metrics to identify codes in the physician fee schedule that were misvalued. Since then Congress has sped up the process of identifying these codes and applied a minimum level of codes that needed to be found and adjusted in the fee schedule for multiple years. For 2018, CMS was able to identify .41-percent in negative adjustments of the 0.5-percent target in statute. This legislation would extend the policy of identifying misvalued codes for one more year.

**Section 2705: Delay in authority to terminate contracts for Medicare Advantage plans failing to achieve minimum quality ratings**

Cures gave the Secretary of HHS temporary authority to delay termination of a plan that has achieved a low star rating for three consecutive years. The star rating system gives an overall rating of the plan's quality and performance for the types of services each plan offers. This section would extend that authority through the 10-year budget window.

**Section 2706: Medicare Improvement Fund**

This section removes all available funds currently held in the Medicare Improvement Fund.

**Section 2707: Payment for outpatient physical therapy services and outpatient occupational therapy services furnished by a therapy assistant**

This policy would pay for Part B therapy services furnished all or in part by a physical and occupational therapy assistant at 85-percent of the rate that would have otherwise been paid for a physician. The therapy assistant must be acting within state license and consistent with Medicare supervision requirements.

**Section 2708: Changes to long-term care hospital payments**

Under current law, site neutral discharges for Long-Term Care Hospitals (LTCHs) are reimbursed a blend of the site neutral payment rate (75-percent for FY2018) and the LTCH rate (25-percent). This section would delay the current law blended payment rate for two years and revert back to the FY2017 blended rate of 50-percent site neutral and 50-percent LTCH. In addition, the policy reduces the LTCH market basket update for FY2018 through FY2026 by 4.6 percent.

### **Section 2709: Non-Budget Neutral Transitional pass-through payment change for certain products**

This section prohibits pass-through payments for all drugs that do not meet the statutory requirements for pass-through status.

### **Section 2710: Third party liability in Medicaid and CHIP**

Strengthens Medicaid's role as the payer of last resort by repealing an outdated statutory requirement that prevents state Medicaid programs from requiring other liable insurers to pay claims for prenatal services before Medicaid pays. (Under current law, state Medicaid programs *must* use a "pay and chase" approach when seeking payment from third parties for Medicaid claims related to claims for prenatal services). This change improves Medicaid third-party liability by requiring that if Medicaid enrollees have another source of health care coverage, that source pays, to the extent of its liability, before Medicaid does.

This section also repeals Section 202(b) of the Bipartisan Budget Act of 2013 (BBA 2013) pertaining to the recovery of Medicaid expenditures from beneficiary liability settlements. (BBA 2013 disrupted private sector settlements by allowing state Medicaid programs to recover all portions of judgments received by Medicaid enrollees. This provision was delayed with bipartisan support in MACRA. This section delays the effective date of BBA 2013's other Medicaid third-party liability changes (as amended) until October 1, 2019.

This section requires the Government Accountability Office (GAO) to study and report on the impact of changes made to third-party liability payments with respect to access to prenatal and preventive pediatric care. This report will help Congress further evaluate these and other potentially future Medicaid third party liability reforms.

Finally, this section applies the above third-party liability reforms to the state Children's Health Insurance Program (CHIP).

### **Section 2711: Treatment of lottery winnings and other lump-sum income for purposes of income eligibility under Medicaid**

Requires a state Medicaid program to count lottery winnings of \$80,000 or higher in more than just the month such payments are received for purposes of determining individual's eligibility for a state Medicaid program under Modified Adjusted Gross Income (MAGI) rules. Impacted individuals could continue to be eligible for medical assistance if denial of eligibility would cause undue medical or financial hardship.

### **Section 2712: Modifying reductions in Medicaid DSH allotments**

Eliminates the Medicaid DSH reductions scheduled for FY2018 and FY2019 under current law. The DSH reduction of \$4 billion in FY2020 under current law remains, and the bill adds a total of \$6 billion in additional DSH reductions to offset the cost of eliminating the FY2018 and FY2019 reductions. These reductions are: in FY2021 (\$3 billion), FY2022 (\$2 billion) and FY2023 (\$1 billion).

### **Section 2713: Medicaid improvement fund rescission**

Rescinds the funds available in the Medicaid Improvement Fund.

### **Section 2714: Sunsetting the exclusion of Biosimilars from the Medicare Part D coverage gap**

In Part D, beneficiaries enter the coverage gap or "donut hole" when the beneficiary's out-of-pocket spending reaches over \$3,750.00. While the majority of Part D beneficiaries do not enter the coverage gap, cost sharing may change once they enter this new phase of the benefit. Brand name drugs, including biologics, pay a 50-percent discount within the coverage gap, these discounts are referred to as the Medicare Coverage Gap Discount Program. The brand and biologic discounts are counted as beneficiary out-of-pocket spending in the coverage gap, even though these discounts are not beneficiary out-of-pocket costs based on the standard definition in other markets. Lower cost biosimilars, however, are not included in the discount program. This, in turn, creates a perverse incentive for beneficiaries to choose the more expensive brand or biologic drug, which increases costs to the federal government. This section would level the playing field between biologics and biosimilars by adding biosimilars to the Medicare Coverage Gap Discount Program. Additionally, by providing the 50-percent discount equally, beneficiary out-of-pocket costs will be reduced and the Medicare program will save money as a result of covering the less expensive medication.

### **Section 2715: Prevention and Public Health Fund**

Modifies funding in the prevention and public health fund to following amounts:

- for FY 2018 and FY 2019: \$900 million
- for FY 2020 and FY 2021: \$1 billion
- for FY 2022 through FY 2027: \$1.1 billion

## **DIVISION G – BUDGETARY EFFECTS**

Sec. 2001. Provides instructions for the treatment of divisions D, E and F as it relates to PAYGO, Senate PAYGO, and scorekeeping guidelines.