# LEGISLATIVE UPDATE

Alliance of Catholic Health Care

**Week of February 5, 2018**

| State Issues | |
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| Key Legislative Hearings this Week | **Single Payer Health Care Debate.** Wednesday's nearly all-day hearing was an opportunity for the proponents of single payer health care legislation to make their case regarding the value of the Single Payer legislation. It began with a presentation by the California Nurses Association (CNA) and their academic expert from the University of Massachusetts at Amherst. They indicated any cost incurred to implement the plan would be offset by cost savings via the elimination of insurance premiums, co-pays and other out-of-pocket costs for individuals, which would help people who delay or skip care because they cannot afford it. In addition, the single payer system would eliminate health plans as the middle men which would streamline care, eliminate barriers to care by use of denials and would reduce the overall cost of care. They acknowledged the many barriers to implementing single payer, including legal barriers, financial barriers and serious challenges in upending the current health care coverage and delivery systems; but CNA indicated it was worth the fight.<br><br>Some members of the Select Committee expressed concern that the assumptions in a study conducted by the academic expert might be overly optimistic about how many federal dollars will continue to flow to California, and whether the Trump Administration would grant waivers to allow federal money to be used for universal care.<br><br>The hearing's second panel included representatives from Health Access California, the California Immigrant Policy Center, Small Business Majority and the California Labor Federation who all expressed support for a single payer system, but focused on improving the current system of care, and working on universal coverage using the current system constructs. Their testimony seemed to focus on increasing support for individuals to buy into current health care insurance options.<br><br>Wednesday's hearing was scheduled to be the last in the series that began last fall, but more hearings have not been completely ruled out. The Select Committee expects to craft a report on the issue they've been studying for months, with concrete recommendations coming out sometime this Spring. Additional details can be found at: http://healthcare.assembly.ca.gov/content/2017-2018-hearings.<br><br>**CURES 2.0.** This week the Assembly Business and Professions Committee held a hearing focused on the Controlled Substance Utilization Review and Evaluation System (CURES). This is the prescription drug monitoring database and reporting system. The goal of CURES 2.0 is to reduce prescription drug abuse and diversion without affecting legitimate medical practice or patient care.<br><br>California law (Health and Safety Code Section 11165.1) requires all California licensed prescribers authorized to prescribe scheduled drugs to register for access to CURES 2.0. A subsequent bill, Senate Bill 482 (Lara, 2016) requires all practitioners to<br><br>*(more)* |

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| Key Legislative Hearings *(continued)* | check the CURES system before prescribing a Schedule II-IV drug and each quarter thereafter, but this mandatory check is not yet in effect. The law requires the Department of Justice (DOJ) to first certify that the database can handle the influx of new requests and be fully staffed to manage practitioners' questions and then give a 6-month grace period before the mandatory check goes into effect. They have not yet been able to do that in the last two years.<br><br>However, at the hearing this week, DOJ announced that it is moving to certify that the database is adequate, and the department will "pull the trigger" on the statute in July – making the physician check of the database mandatory 6 months later. DOJ indicated they have been hiring more staff in order to accommodate questions and support for physicians, pharmacists and others who will need to access the database. They also indicated they have made upgrades to the system and are currently performing tests on it to ensure its functionality. You can access DOJ website covering this topic here: https://oag.ca.gov/cures and see the background paper from the B&P Committee here: http://abp.assembly.ca.gov/sites/abp.assembly.ca.gov/files/hearings/CURES%20Background%20Paper%20180131.pdf |
| Budget Update: Fact Sheets and Hearing Dates | The Department of Health Care Services has released Fact Sheets to accompany some of the budget trailer bill language they issued last week. Please see links below for the Administration's write ups on their 340B Medi-Cal proposal and the changes to the Hospital Quality Assurance Fee administration. Despite the lengthy fact sheet on the 340B proposal, more questions remain and many in the hospital community are working together to obtain more details regarding the plan.<br><br>▪ 340B Proposal Fact Sheet<br>▪ Hospital QAF Fact Sheet<br><br>Also note that as of this writing, the Assembly Budget Subcommittee has plans to hear the 340B issue on April 30th and the Proposition 55 issue on March 5th. More details on the Senate budget schedule coming soon. |
| Alliance Summary and Status Report | Next Friday, February 16, is the legislative deadline for new bill introductions. Given the many distractions in the Capitol, the flow of new bills has been slow. However, we anticipate a ramp up of bills in print over the next week or so. Meantime, attached is the most recent Alliance Legislative Summary and Status report on bills of interest to the Catholic health care ministry. |
| New Report on Use of Ambulatory Surgery Centers | The California Health Care Foundation has published a new report on the increase in use of California's Ambulatory Surgery Centers, titled "A Black Box of Care." They state that many surgeries are performed in freestanding, or "same-day," ambulatory surgery centers (ASCs), and the number of freestanding ASCs in California has increased dramatically over the past 11 years. Due to a legal decision that removed reporting requirements for ASCs in the state, they have concerns that little is known about the volume of procedures, type of procedures, and financial operation of the vast majority of these facilities. Their report looks at the most recent data on the supply, use, quality, and finances of freestanding ASCs in California, as well as trends from 2005 to 2016. Their key findings include:<br><br>▪ From 2005 to 2016, the number of Medicare-approved freestanding ASCs increased by 26%, from 626 to 791, while the number of operating rooms (ORs) in these facilities increased even more, from 1,311 to 1,905 (45%). In 2016, California had slightly fewer freestanding ASC ORs per 100,000 population than the average state.<br><br>*(more)* |

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| New Report on Use of Ambulatory Surgery Centers *(continued)* | ▪ Despite the decline in the number of facilities and surgeries reported to the Office of Statewide Planning and Development (OSHPD), the number of surgeries per facility remained relatively stable, around 2,500.<br>▪ Among freestanding ASCs that reported data to OSHPD, private insurance was the dominant payer, representing 41% of ASC encounters, while Medi-Cal covered one-third.<br>▪ In 2017, the Centers for Medicare & Medicaid Services (CMS) started publicly reporting quality measures for ASCs. In the first set of measures reported, California performed similarly to the national average.<br><br>The full report and all of its charts, as well as a link to the previous year's report are part of CHCF's California Health Care Almanac, and can be found at: https://www.chcf.org/resource-center/california-health-care-almanac/. |
| **Federal Issues** | |
| Budget Deal Approved \| Funding thru March 23 | With the federal government funding expired and the government beginning to shut down, after midnight the Senate finally voted to end debate and then subsequently approved a massive two-year budget deal. The delayed vote was the result of a daylong protest on the floor by Senator Rand Paul (R-KY). Early this morning, the House voted 240-186 to approve the budget deal sending the package to President Donald Trump. The budget package also includes stopgap funding through March 23. Attached is a section-by-section summary of the Health and Human Services provisions. |

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# Alliance of Catholic Health Care
# Legislative Summary and Status 2/9/2018

## Behavorial and Mental Health

**AB 451** **(Arambula D) Health facilities: emergency services and care.**
**Location:** 9/1/2017-S. 2 YEAR
**Summary:** Would specify that a psychiatric unit within a general acute care hospital, a psychiatric health facility, or an acute psychiatric hospital, excluding certain state hospitals, regardless of whether it operates an emergency department, is required to provide emergency services and care to treat a person with a psychiatric emergency medical condition who has been accepted by the facility, as specified, if the facility has appropriate facilities and qualified personnel. The bill would make conforming changes to related provisions.

**Position**
Watch

**AB 1136** **(Eggman D) Health facilities: residential mental or substance use disorder treatment.**
**Location:** 2/5/2018-S. HEALTH
**Summary:** Would require the State Department of Public Health to develop and submit a proposal to solicit a grant under the federal 21st Century Cures Act to develop a real-time, Internet-based database to collect, aggregate, and display information about beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential substance use disorder treatment facilities.

**Position**
Watch

**AB 1372** **(Levine D) Crisis stabilization units: psychiatric patients.**
**Location:** 9/6/2017-S. INACTIVE FILE
**Summary:** Would authorize a certified crisis stabilization unit designated by a mental health managed care plan, at the discretion of the mental health managed care plan, to provide medically necessary crisis stabilization services to individuals beyond the service time of 24 hours in those cases in which the individual needs inpatient psychiatric care or outpatient care and inpatient psychiatric beds or outpatient services are not reasonably available. The bill would require a person who is placed under, or who is already under, a 72-hour involuntary hold because, based on probable cause, the person, as a result of a mental disorder, is a danger to others, or to himself or herself, or is gravely disabled, to be credited for the time detained at a certified crisis stabilization unit.

**Position**
Watch

## End of Life/Palliative Care

**AB 282** **(Jones-Sawyer D) Aiding, advising, or encouraging suicide: exemption from prosecution.**
**Location:** 1/18/2018-S. DESK
**Summary:** Current law makes a person who deliberately aids, advises, or encourages another to commit suicide guilty of a felony. This bill would prohibit a person whose actions are authorized pursuant to the End of Life Option Act from being prosecuted for deliberately aiding, advising, or encouraging suicide.

**Position**
Pending Review

**AB 937** **(Eggman D) Health care decisions: order of priority.**
**Location:** 7/21/2017-S. 2 YEAR
**Summary:** The Health Care Decisions Law, among other things, provides for an individual's use of a request regarding resuscitative measures, which is a written document, signed by an individual with capacity or a legally recognized health care decisionmaker for the individual, and the individual's physician, that directs a health care provider regarding resuscitative measures for the individual. This would provide that, to the extent of that conflict, the most recent order signed by the individual or instruction made by the individual is effective. The bill would deem a request regarding resuscitative measures signed by specified persons on behalf of the individual to be signed by the individual. The bill would also make technical conforming changes.

**Position**

Watch

**SB 481** **(Pan D) Long-term health facilities: informed consent.**
**Location:** 7/14/2017-A. 2 YEAR
**Summary:** Current law requires the attending physician of a resident in a skilled nursing facility or intermediate care facility who prescribes or orders a medical intervention of a resident that requires the informed consent of a patient who lacks the capacity to provide that consent, as specified, to inform the skilled nursing facility or intermediate care facility. Current law requires the facility to conduct an interdisciplinary team review of the prescribed medical intervention prior to the administration of the medical intervention. This bill would, before implementing a medical intervention that requires informed consent for a resident who lacks capacity to make health care decisions and there is no person with legal authority able and willing to make those decisions, require the physician, skilled nursing facility, or intermediate care facility, to promptly notify the resident, orally and in writing, that it has been determined that the resident lacks capacity, and other information, as specified.

**Position**
Support

## Health Care Reform

**SB 562** **(Lara D) The Healthy California Act.**
**Location:** 7/14/2017-A. 2 YEAR
**Summary:** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill, the Healthy California Act, would create the Healthy California program to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state.

**Position**
Watch

## Hospital Operations

**AB 1250** **(Jones-Sawyer D) Counties: contracts for personal services.**
**Location:** 9/5/2017-S. RLS.
**Summary:** Would establish specific standards for the use of personal services contracts by counties. The bill would allow a county or county agency to contract for personal services currently or customarily performed by employees, as applicable, when specified conditions are met. The bill would exempt certain types of contracts from its provisions, and would exempt a city and county from its provisions. By placing new duties on local government agencies, the bill would impose a state-mandated local program. The bill also would provide that its provisions are severable.

**Position**
Oppose

**AB 1795** **(Gipson D) Emergency medical services: community care facilities.**
**Location:** 1/22/2018-A. HEALTH
**Summary:** Would authorize a local emergency medical services agency to submit, as part of its emergency services plan, a plan to transport specified patients to a community care facility, as defined, in lieu of transportation to a general acute care hospital. The bill would make conforming changes to the definition of advanced life support to include prehospital emergency care provided before and during, transport to a community care facility, as specified.

**Position**
Support

**SB 538** **(Monning D) Hospital contracts.**
**Location:** 7/14/2017-A. 2 YEAR
**Summary:** This bill, the Health Care Market Fairness Act of 2017, would prohibit contracts between hospitals and contracting agents, health care service plans, or health insurers from containing certain provisions, including, but not limited to, setting payment rates or other terms for nonparticipating affiliates of the hospital, requiring the contracting agent, plan, or insurer to keep the contract's payment rates confidential from any payor, as defined, that is or may become financially responsible for the payment, and requiring the contracting agent, plan, or insurer to submit to arbitration, or any other alternative dispute resolution program, any claims or causes of action that arise under state or federal antitrust laws after those claims or causes of action arise, except as provided.

**Position**
Oppose

## Religious Freedom

**SB 1023** **(Hernandez D) Reproductive health care coverage.**
**Location:** 2/7/2018-S. RLS.
**Summary:** Current law provides for the regulation of health insurers by the Department of Insurance. Current law prohibits a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, from requiring an enrollee or insured to receive a referral prior to receiving coverage or services for reproductive or sexual health care. This bill would declare the intent of the Legislature to amend this bill to include provisions that would provide access to sexual and reproductive health care by ensuring care modalities through alternative delivery systems and platforms.

**Position**
Pending Review

## Social Determinants of Health

**SB 100** **(De León D) California Renewables Portfolio Standard Program: emissions of greenhouse gases.**
**Location:** 9/8/2017-A. U. & E.
**Summary:** The Legislature has found and declared that its intent in implementing the California Renewables Portfolio Standard Program requires the PUC is to attain, among other targets for sale of eligible renewable resources, the target of 50% of total retail sales of electricity by December 31, 2030. This bill would revise the above-described legislative findings and declarations to state that the goal of the program is to achieve that 50% renewable resources target by December 31, 2026, and to achieve a 60% target by December 31, 2030.

**Position**
Support

**Total Measures: 12**
**Total Tracking Forms: 12**

**Health and Human Services Provisions**

*Section-By-Section Summary*

## TITLE I – CHIP

**Sec. 50101. Funding extension of the Children's Health Insurance Program through fiscal year 2027.** This section extends funding for CHIP for four additional years (FY2024 through FY2027), appropriating such sums as are necessary to fund the program based on the program's existing allotment structure. The section also extends the Child Enrollment Contingency Fund, the Qualifying States Option, the Express Lane Eligibility option, and continues to require states to maintain eligibility levels for CHIP children through FY2027.

**Sec. 50102. Extension of pediatric quality measures program.** This section extends funding for the pediatric quality measures program and requires states to report on a core set of pediatric quality measures, which had previously been optional.

**Sec. 50103. Extension of outreach and enrollment program.** This section extends funding for outreach enrollment grants at $48 million for FY2024 through FY2027 and allows a portion of the funds to be used for evaluation and technical assistance.

## TITLE II - MEDICARE EXTENDERS

**Section 50201. Extension of work Geographic Practice Cost Index (GPCI) floor.** This section would increase payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average by extending the current 1.0 physician work GPCI floor for two years through December 31, 2019.

**Section 50202. Repeal of Medicare payment cap for therapy services; replacement with limitation to ensure appropriate therapy.** This section would permanently repeal the annual payment limits ("caps") for outpatient therapy services, including physical therapy, speech-language pathology services, and occupational therapy, beginning January 1, 2018. It would require continuation of the current practice that a modifier be included on claims over the current exception threshold indicating that the services are medically necessary. It would also lower the targeted manual medical review threshold above which claims may be subjected to review of medical necessity documentation from the current per-beneficiary therapy expenditure amount of $3,700 to $3,000.

**Section 50203. Medicare ambulance services.** This section would extend the temporary increase in ambulance fee schedule rates for all ground ambulance services (i.e., 2 percent urban add-on payment and 3 percent rural add-on payment) and the super-rural ambulance add-on payments for five years through December 31, 2022. It would also require the Secretary of Health and Human Services (HHS), in consultation with stakeholders, to develop a data collection system for ambulance providers and suppliers to collect cost, revenue, utilization, and other information determined appropriate by the Secretary.

**Section 50204. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals.** The low-volume adjustment is based on the concept that large hospitals benefit from certain economies of scale that are not available to small hospitals with limited discharges. To account for the higher incremental costs per discharge, certain low-volume hospitals receive a payment adjustment. Specifically, hospitals with 200 or fewer Medicare discharges receive a 25 percent payment increase, decreasing on a sliding scale to 0 percent for hospitals with more than 1,600 Medicare discharges. The Medicare Payment Advisory Commission (MedPAC) has reported that this adjustment is not well targeted because hospitals may have a small number of Medicare patients while also treating a large number of non-Medicare patients. This section would extend Medicare low-volume hospital payments for five years through September 30, 2022. Current law low-volume payments would continue unchanged for one year through September 30, 2018. This provides one year for qualifying hospitals to transition into a modified low-volume payment adjustment based on total discharges rather than Medicare discharges. The modified payment adjustments based on total discharges would begin October 1, 2018. For fiscal year 2019 through fiscal year 2022, the low-volume adjustment standard would be set at 25 percent for hospitals with 500 or fewer total discharges, decreasing on a sliding scale to 0 percent for hospitals with more than 3,800 total discharges.

**Section 50205. Extension of the Medicare-dependent hospital (MDH) program.** Medicare-dependent hospitals (MDHs) are rural hospitals with no more than 100 beds that serve a higher percentage of Medicare beneficiaries. These hospitals receive inpatient prospective payment system (IPPS) rates plus 75 percent of the difference between the IPPS payment and a hospital-specific cost per discharge amount that is calculated using base-year costs. This section would extend the MDH program for five years through September 30, 2022. No later than two years after the date of enactment, the GAO would be required to complete a study on the MDH program.

**Section 50206. Extension of funding for quality measure endorsement, input, and selection; reporting requirements.** Section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required the Secretary of Health and Human Services (HHS) to contract with a consensus-based entity (e.g., National Quality Forum or NQF) to carry out specified duties related to quality measurement and performance improvement. According to the Centers for Medicare & Medicaid Services (CMS), carryover funding allocated under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) remains unobligated and available for expenditure in future years. To supplement those existing funds, this section would provide $7.5 million for each of fiscal years 2018 and 2019 to ensure CMS has the resources necessary to fulfill the agency's statutory obligations. This section would also institute enhanced transparency of the dollars spent under Section 1890 and 1890A of the Social Security Act (SSA) by requiring new and updated reports to Congress describing how the funds appropriated to the Secretary of HHS are used to help CMS meet Medicare and Medicaid program quality measurement goals now and in the future.

**Section 50207. Extension of funding outreach and assistance for low-income programs; State health insurance assistance program reporting requirements.** In 1990, the Secretary of HHS was required to establish a beneficiary assistance program, which later became known as the State Health Insurance Assistance Program (SHIP), to help Medicare beneficiaries with

information and counseling. Congress has since appropriated funding for this program, in addition to other programs to assist low-income Medicare beneficiaries administered by the Area Agencies on Aging, the Aging and Disability Resource Centers, and the National Center for Benefits and Outreach Enrollment.

This section would extend for two years, at current law levels, funding for outreach and education activities for Medicare beneficiaries, specifically, for the State Health Insurance Programs (SHIPs), Area Agencies on Aging, Aging and Disability Resource Centers, and The National Center for Benefits and Outreach Enrollment. This section would also require the Administration for Community Living to report on the amount and use of funding provided to states.

**Section 50208. Extension of home health rural add-on.** This section would extend the home health add-on and improve the targeting of future payments in order to protect the Medicare Trust Fund. Specifically, the add-on would be extended at current levels for 2018. Beginning in 2019, the home health add-on would increase from 3 to 4 percent for counties with a population density of 6 or fewer individuals per square mile. This payment add-on would then phase down to 3 percent in 2020, 2 percent in 2021 and 1 percent in 2022. According to the Medicare Payment Advisory Commission (MedPAC), many rural counties have well above average utilization of home health services and face little barriers to access home health services. In these counties, the home health add-on would be reduced to 1.5 percent in 2019 and 0.5 percent in 2020. In all other rural counties not described above, the home health add-on would be extended at the current law rate in 2019 and then reduced to 2 percent in 2020 and 1 percent in 2021. This section would require, beginning in 2019, home health agencies to submit to CMS the county in which the home health services was furnished. Finally, this section would require the HHS Office of the Inspector General to conduct an analysis of home health utilization and provide to Congress any appropriate recommendations based on this analysis.

## TITLE III – CREATING HIGH-QUALITY RESULTS AND OUTCOMES NECESSARY TO IMPROVE CHRONIC (CHRONIC) CARE

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

**Section 50301. Extending the Independence at Home Demonstration Program.** This section would extend and expand the Medicare Independence at Home demonstration to provide a broader base of experience to inform future legislative efforts. Specifically, it would extend the length of the demonstration by two years; increase the cap on the total number of participating beneficiaries from 10,000 to 15,000; and give practices three years to generate savings against their spending targets.

**Section 50302. Expanding access to home dialysis therapy.** This section would expand the ability of beneficiaries on home dialysis to receive required monthly clinical assessments to monitor their condition using telehealth, beginning January 1, 2019. Specifically, it would expand the number of originating sites from which the beneficiary can have a telehealth assessment with his or her clinician to include freestanding dialysis facilities and the patient's

home and eliminate any geographic restriction for all originating sites. Medicare would not provide a separate payment for the originating site fee if the service is furnished in the home. A beneficiary would be required to receive the first three clinical assessments and at least one of every three assessments thereafter through an in person face-to-face encounter. Providers would be allowed to furnish equipment to facilitate telehealth to beneficiaries receiving home dialysis in certain situations.

***Subtitle B – Advancing Team-Based Care***

**Section 50311. Providing continued access to Medicare Advantage special needs plans for vulnerable populations.** The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) established a new Medicare Advantage (MA) coordinated care plan to provide services for individuals with special needs. Special needs plans (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. Among other changes, the Affordable Care Act extended SNP authority through December 31, 2013, and temporarily extended authority through the end of 2012 for dual eligible SNPs without contracts with state Medicaid programs to continue to operate, but in their current service areas. After 2012, dual eligible SNPs, new and renewing, were required to have contracts with state Medicaid agencies. Several subsequent laws have extended SNP authority without interruption; most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended SNP authority through December 31, 2018.

In this section, the Medicare-Medicaid Coordination Office would be directed to serve as a dedicated point of contact for states to assist with Medicare and Medicaid integration efforts, and the Secretary would be required to work through this office to establish a unified grievances and appeals process for individuals enrolled in a D-SNP. This section would permanently authorize the I-SNP, D-SNP and C-SNP, if certain requirements are met. By 2021, a D-SNP contract would be required to have a unified grievances and appeals procedure in place, and by 2021, a D-SNP would be required to integrate Medicare and Medicaid long-term services and supports and/or behavioral health services by meeting one of three requirements. Failure to meet one of the three integration requirements would result in suspension of enrollment. MedPAC, in consultation with MACPAC, would be required to conduct a study and report to Congress on the quality of D-SNPs. Beginning in 2020, a C-SNP would be required to meet additional requirements to improve care management for the beneficiaries with severe or disabling chronic conditions enrolled in the plan. By January 1, 2022, and every five years thereafter, the Secretary would be required to update the list of chronic conditions eligible for participation in a C-SNP. The updated list must include HIV/AIDS, end-stage renal disease, and chronic and disabling mental illness. The Secretary may consider implementing the quality star rating system at the plan level for SNPs and all MA plans. GAO would be instructed to conduct a study and report on state-level integration between D-SNPs and Medicaid within two years of enactment.

***Subtitle C – Expanding Innovation and Technology***

**Section 50321. Adapting benefits to meet the needs of chronically ill Medicare Advantage enrollees.** Under Medicare Advantage (MA) private health plans are paid a per-person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll. Unlike original Medicare, where providers are paid for each item or service provided to a beneficiary, an MA plan receives the same capitated monthly payment regardless of how many or few services a beneficiary actually uses. The plan is at-risk if aggregate costs for its enrollees exceed program payments and beneficiary cost sharing; conversely, in general, the plan can retain savings if aggregate enrollee costs are less than program payments and cost sharing. Currently, an 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. CMS has also proposed a regulation that would permit MA plans to offer a benefit package that includes different cost-sharing requirements or benefits to help MA plans better serve the most vulnerable 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 (during the testing phase) to determine whether savings are achieved without negatively impacting quality.

**Section 50322. Expanding supplemental benefits to meet the needs of chronically ill Medicare Advantage enrollees.** All Medicare Advantage (MA) plans must offer required Medicare benefits (except hospice) and may offer additional or supplemental benefits. Mandatory supplemental benefits are covered by the MA plan for every person enrolled in the plan and are paid for either through plan rebates, a beneficiary premium, or cost sharing. Optional supplemental benefits must be offered to all plan enrollees, but the enrollee may choose to pay an additional amount to receive coverage of the optional benefit; optional benefits cannot be financed through plan rebates.

An MA plan must adhere to specific rules regarding the supplemental benefits that it can offer. First, the MA plan cannot design a benefit plan that is likely to substantially discourage enrollment by certain MA eligible individuals. Further, supplemental benefits (a) may not be Medicare Part A or Part B required services, (b) must be primarily health related with the primary purpose to prevent, cure, or diminish an illness or injury, and (c) the plan must incur a cost when providing the benefit. Items that are primarily for comfort or are considered social services would not qualify as supplemental benefits. Examples of supplemental benefits include the following:

1. Additional inpatient hospital days in an acute care or psychiatric facility,
2. Acupuncture or alternative therapies,
3. Counseling services,
4. Fitness benefit,
5. Enhanced disease management, and
6. Remote Access Technologies (including Web/Phone based technologies).

CMS proposed a regulation that would allow MA plans greater flexibility to offer targeted supplemental benefits.

This section would allow an MA plan to offer a wider array of 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. The section would allow an MA plan the flexibility to provide targeted supplemental benefits to specific chronically ill enrollees.

**Section 50323. Increasing convenience for Medicare Advantage enrollees through telehealth.** Telehealth is the use of electronic information and telecommunications technologies to support remote clinical health care, patient and professional health-related education, and other health care delivery functions. While Medicare beneficiaries may receive telehealth services in a variety of settings, under current law (SSA Section 1834(m)), the Medicare program recognizes and pays for only certain Part B telehealth services. These services must be either (1) remote patient and physician/professional face-to-face services delivered via a telecommunications system (e.g., live video conferencing), or (2) non face-to-face services that can be conducted either through live video conferencing or via store and forward telecommunication services in the case of any Federal telemedicine demonstration program in Alaska or Hawaii. Typically, Medicare coverage for remote face-to-face services includes payments (1) to physicians or other professionals (at the distant site) for the telehealth consultation, and (2) to the facility where the patient is located (the originating site).

An MA plan may provide basic telehealth benefits as part of the standard benefit; for example, telemonitoring and web-based and phone technologies can be used to provide telehealth services. Medicare Advantage Prescription Drug (MAPD) may choose to include telehealth services as part of their plan benefits, for instance, in providing medication therapy management (MTM). However, while there is nothing to preclude Medicare Advantage (MA) from providing telemedicine or other technologies that they believe promote efficiencies beyond what is covered in the traditional Medicare program, those services and technologies are not separately paid for by Medicare and plans must use their rebate dollars to pay for those services as a supplemental benefit.

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 would be required to solicit comments on: what types of telehealth services, including but not limited to those provided through supplemental health care benefits, such as remote patient monitoring, secure messaging, store and forward technologies, and other non-face-to-face communication; 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 50324. Providing accountable care organizations the ability to expand the use of telehealth.** While Medicare beneficiaries may receive telehealth services in a variety of settings, under current law (SSA Section 1834(m)), the Medicare program restricts telehealth payments by the type of services provided, the geographic location where the services are delivered, the type of institution delivering the services, and the type of health provider. While there is nothing

to preclude ACOs from providing telemedicine or other technologies that they believe promote efficiencies, those services and technologies are not separately paid for by Medicare. Traditionally telehealth has been viewed as a tool to improve access to services, but interest is growing to see if telehealth has the potential to reduce health care costs. Telehealth may have the potential to replace some face-to-face office visits, reduce emergency room visits, and prevent hospitalizations. Telehealth may also keep beneficiaries in closer, more consistent contact with providers.

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 the Center for Medicare & Medicaid Innovation (CMMI) as determined appropriate by the Secretary. 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 50325. Expanding the use of telehealth for individuals with stroke.** 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 January 1, 2019. Specifically, it would eliminate the geographic restriction as to permit payment to physicians furnishing the telehealth consultation service in all areas of the country. Medicare would not provide a separate originating site payment to newly eligible originating sites.

***Subtitle D – Identifying the Chronically Ill Population***

**Section 50331. Providing flexibility for beneficiaries to be part of an accountable care organization.** Medicare fee-for-service beneficiaries are assigned to ACOs based on their utilization of primary care services provided by a physician who is an ACO provider and/or supplier. Beneficiaries currently do not have the option of choosing to participate directly in an ACO (aside from seeking care from a particular provider), but are notified if their primary care provider is an ACO participant. Beneficiaries who receive at least one primary care service from a primary care physician within the ACO may be assigned to that ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO. Beneficiaries who have not had a primary care service furnished by any primary care physician either inside or outside the ACO, but who receive at least one primary care service from any physician within the ACO, are assigned to that ACO if the beneficiary receives a plurality of his or her primary care services from specialist physicians.

The manner in which Medicare fee-for-service beneficiaries are assigned to an ACO affects how the ACO can tailor care for its beneficiaries and how the ACO is evaluated. Under current

Centers for Medicare & Medicaid (CMS) rules, Medicare determines the method of beneficiary attribution, rather than giving ACOs the option to choose the assignment methodology that best fits their model of care. Medicare fee-for-service beneficiaries can be assigned to an ACO either retrospectively or prospectively depending on the ACO's track. Prospective assignment allows ACOs to identify beneficiaries for whom they will be held accountable and proactively take steps to connect these beneficiaries to appropriate care, but also holds ACOs accountable for the spending for these beneficiaries even if the ACO providers do not provide the care. Retrospective assignment ensures that ACOs are held accountable for the spending only of those beneficiaries who receive most of their primary care services from ACO providers, but they may not know who those beneficiaries are until the end of the year.

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 E – Empowering Individuals and Caregivers in Care Delivery***

**Section 50341. Eliminating barriers to care coordination under accountable care organizations.** ACOs are collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals, federally qualified health centers, rural health clinics, and others. In the Medicare Shared Savings Program (MSSP) specifically, ACOs are designed to provide incentives to providers to manage care across the continuum by reducing health care costs while meeting quality performance standards. The ACO mission is to ensure that patients, especially the chronically ill, receive the right care at the right time in the right care setting, while avoiding unnecessary duplication of services and preventing medical errors. Delaying or forgoing preventive care – especially care related to chronic disease management – may lead to increased costs and poor health outcomes. ACOs are accountable for the health outcomes and overall costs of their attributed beneficiaries. As a result, ACO aligned beneficiaries could be encouraged to seek out preventive care or chronic disease management if the cost to access those services is manageable.

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 Fiscal Year (FY) 2017 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 than October 1, 2023.

**Section 50342. GAO study and report on longitudinal comprehensive care planning services under Medicare Part B.** 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.

***Subtitle F – Other Policies to Improve Care for the Chronically Ill***

**Section 50351. GAO study and report on improving medication synchronization.** This section would direct the Government Accountability Office 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.

**Section 50352. GAO study and report on impact of obesity drugs on patient health and spending.** This section would direct the Government Accountability Office 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.

**Section 50353. HHS study and report on long-term risk factors for chronic conditions among Medicare beneficiaries**. This section would require the Secretary 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.

**Section 50354. Providing prescription drug plans with parts A and B claims data to promote the appropriate use of medications and improve health outcomes.** Under current law, standalone prescription drug plans (PDPs) provide Medicare's prescription drug benefit to fee-for-service (FFS) beneficiaries. Certain Medicare beneficiaries who meet criteria described in statute are eligible to enroll in medication therapy management (MTM) programs offered by PDPs. MTM's purpose is to coordinate prescription drugs for high-cost beneficiaries. However, PDPs do not have access FFS utilization data that may aid the PDP in coordination efforts. This differs from MA-PDs which are responsible for providing both Medicare's prescription drug benefit but also Medicare Part A and Part B's medical benefits and has access to all relevant data.

This section would require the Secretary to establish a process, beginning in plan year 2020, by which a Part D plan sponsor may submit a request to CMS for claims data under Parts A and B. These data, which would include claims as recent as possible, would be for the purposes of: optimizing therapeutic outcomes through improved medication use; improving care coordination as to prevent adverse health outcomes; and other purposes determined by the Secretary. Plan sponsors would be prohibited from using these data to: inform Part D coverage determinations; conduct retroactive review of coverage indications; facilitate enrollment changes to a different PDP or an MA-PD offered by the same parent organization; market benefits; and for other

purposes determined by the Secretary to protect the identity of Medicare beneficiaries and to protect the security of personal health information.

## TITLE IV – PART B IMPROVEMENT ACT AND OTHER PART B ENHANCEMENTS

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

**Section 50401. Home infusion therapy services temporary transitional payment.** This section would create a temporary payment beginning January 1, 2019 for furnishing a drug or biologic that is infused through an item of durable medical equipment to a beneficiary in the home. This temporary payment would be in place until the permanent benefit for home infusions previously established by Congress is implemented in 2021.

**Section 50402. Orthotist's and prosthetist's clinical notes as part of the patient's medical record.** This section would ensure that information provided by orthotists and prosthetists, who evaluate and fit the beneficiary, is considered as part of the documentation that supports the medical necessity for the orthoses or prostheses.

**Section 50403. Independent accreditation for dialysis facilities and assurance of high quality surveys.** This section would allow dialysis facilities to seek the accreditation that is needed to be able to bill Medicare for dialysis services from private organizations approved by Medicare.

**Section 50404. Modernizing the application of the Stark rule under Medicare.** This section would codify the changes CMS made in regulations to streamline and clarify rules for providers regarding compliance with the Stark law, including leases that were in violation and when signatures were required to document the terms of legal arrangements.

### *Subtitle B – Additional Medicare Provisions*

**Section 50411. Making permanent the removal of the rental cap for durable medical equipment under Medicare with respect to speech generating devices.** This section would make Medicare coverage of speech generating devices under "routinely purchased durable medical equipment" permanent, as opposed to using the rental item classification that may disrupt beneficiary access in certain situations.

**Section 50412. Increased civil and criminal penalties and increased sentences for Federal health care program fraud and abuse.** This section would update both the civil and criminal penalties for fraud and abuse in federal health programs that have largely remained static over the past 20 years.

**Section 50413. Reducing the volume of future EHR-related significant hardship requests.** This section would remove a requirement that CMS make meaningful use standards more stringent over time, increasing the likelihood that providers will be able to comply with those standards.

**Section 50414. Strengthening rules in case of competition for diabetic testing strips.** This section would require CMS to more rigorously enforce the requirement that durable medical equipment suppliers in the competition bidding program offer at least 50 percent of the diabetes test strip brands used by beneficiaries. It would also codify and enhance the regulatory prohibition against suppliers unduly influencing beneficiaries to switch from their preferred brand of diabetes supplies.

## TITLE V – OTHER HEALTH EXTENDERS

**Section 50501. Extension for family-to-family health information centers.** This section extends Family-to-Family Health Information Center funding through fiscal year 2019 and provides an additional $1 million for each of fiscal years 2018 and 2019 to support the development of centers in the territories and at least one center for Indian tribes. This program, administered by the Health Resources and Services Administration (HRSA), provides grants to support family-staffed organizations in each state to assist families of children with disabilities and special health care needs.

**Section 50502. Extension for sexual risk avoidance education.** This section extends abstinence only programs and associated funding through fiscal year 2019, updates the name and purposes of the program, aligns funding policies, and includes a national evaluation. This program provides funds to states to provide education exclusively focused on sexual risk avoidance (meaning voluntarily refraining from sexual activity).

**Section 50503. Extension for personal responsibility education.** This section extends the Personal Responsibility Education Program (PREP) and associated funding through fiscal year 2019, extends grants, and expands the target population to include youth who are victims of human trafficking. PREP provides states, community groups, tribes, and tribal organizations with grants to implement evidence-based, or evidence-informed, innovative strategies for teen pregnancy and HIV/STD prevention, youth development, and adulthood preparation for young people.

## TITLE VI – CHILD AND FAMILY SERVICES AND SUPPORTS EXTENDERS

### *Subtitle A – Continuing the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program*

**Section 50601. Continuing evidence-based home visiting program.** This section continues MIECHV at the current-law level of $400 million per year for FY2018 through FY2022. This program provides states, territories, and tribes with grants to support evidence-based home visiting programs for at-risk families.

**Section 50602. Continuing to demonstrate results to help families.** This section requires states continue to show MIECHV is improving the lives of families by demonstrating improvements for the eligible families participating in the program in at least four of six benchmark areas

specified in law, as well as develop a plan to improve outcomes if the state fails to demonstrate improvement (current law required states to demonstrate improvement in the first three years after the program was fully implemented—FY2012 through FY2014). This section also clarifies that states need only measure and demonstrate improvements in the benchmark areas the home visiting programs selected by the state are intended to improve to reduce unnecessary tracking and reporting (instead of requiring the state to measure and demonstrate improvements in all areas regardless of whether the model is designed to impact those areas or not).

**Section 50603. Reviewing statewide needs to target resources.** This section requires states to conduct a follow-up statewide needs assessment by October 1, 2020 to make sure states continue to review where home visiting services are most needed (current law required states to conduct a needs assessment before receiving funds in FY2011 as part of the first authorization of funding). It also specifies the statewide needs assessment can be combined or coordinated with the assessment required to receive Maternal and Child Health Services Block Grant funds to reduce duplication and increase program coordination.

**Section 50604. Improving the likelihood of success in high-risk communities.** This section requires that states continue to prioritize serving families in communities identified as most in need of home visiting services, while also allowing them to take into account community resources and other service delivery requirements that may need to be developed for communities to operate at least one home visiting program and contribute to the success of a home visiting program in the state.

**Section 50605. Option to fund evidence-based home visiting on a pay for outcome basis.** This section allows states to use up to 25 percent of their funding to pay for home visiting services on a "pay-for-outcome" basis, where a state would be able to contract with providers so they only pay for services if a rigorous, independent evaluation confirms the services achieved the desired outcomes.

**Section 50606. Data exchange standards for improved interoperability.** This section adds language previously added to Temporary Assistance for Needy Families, Child Support Enforcement, Unemployment Insurance, and child welfare programs requiring HHS to develop data standards for home visiting programs that will help state agencies and the federal government more easily exchange information to ensure the integrity of programs and improve services for families in need, all while maintaining privacy standards.

**Section 50607. Allocation of funds.** HHS allocates money for MIECHV based on the share of children under age five in families at or below 100 percent of the federal poverty line living in each state and territory. However, HHS uses U.S. Census Bureau data that does not include data for the territories, so they do not receive an amount proportional to the number of children in poverty. This section would allow HHS to continue to use Census Bureau data for states, making sure they use an appropriate alternative data source when determining funding for territories.

***Subtitle B – Extension of Health Professions Workforce Demonstration Projects.***

**Section 50611. Extension of health workforce demonstration projects for low-income individuals.** This section extends the Health Workforce Demonstration Project, which provides funding to help low-income individuals obtain education and training in high-demand, well-paid, health care jobs, through fiscal year 2019 at the current funding level.

## TITLE VII – FAMILY FIRST PREVENTION SERVICES ACT

### *Subtitle A – Investing in Prevention and Supporting Families*

**Section 50701. Short title.** This subtitle may be cited as the "Family First Prevention Services Act".

**Section 50702. Purpose.** This section contains the purpose of this subtitle, which is to enable states to use federal funds available under title IV-B and title IV-E of the Social Security Act to provide more effective support to children and families to prevent foster care placements.

Part I – Prevention Activities Under Title IV-E

**Section 50711. Foster Care Prevention Services and Programs.** This section amends the title IV-E foster care and permanency program to give states and tribes the option of receiving partial federal reimbursement for state expenditures to provide services that enable children to remain safely at home, or with a kin care provider, instead of entering foster care. These prevention activities would include mental health and substance abuse prevention and treatment services (to treat the major reasons children come into foster care today), and in-home parent skill-based programs (including parenting skills training, parent education, and individual and family counseling). This section would also allow small states (with less than 200,000 children) to select from three possible base years when determining their maintenance of effort requirement, clarify that the receipt of prevention services does not disqualify a child from being eligible for IV-E foster care at a later date, and clarify that territories are eligible for prevention funding.

**Section 50712. Foster care maintenance payments for children with parents in a licensed residential family-based treatment facility for substance abuse.** This section allows states to receive title IV-E foster care maintenance payment support, for up to 12 months, for children in foster care who are placed with their parent in a licensed residential family based treatment facility (preventing the need to separate children and parents and place the child with foster parents).

**Section 50713. Title IV-E payments for evidence-based kinship navigator programs.** This section allows states to claim a 50 percent federal reimbursement for the cost of operating programs that provide referral services to relatives who take in children so they can avoid being placed in foster care (called "kinship navigator" programs), provided the HHS Secretary determines the programs are operated in accordance with promising, supported, or well-supported practices.

Part II – Enhanced Support Under Title IV-B

**Section 50721. 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.** This section permits the use of capped Promoting Safe and Stable Families (PSSF) funding for family reunification services to be provided to a child in foster care (and to his or her parent(s)/primary caregiver), regardless of the amount of time the child has been in foster care.

**Section 50722. Reducing bureaucracy and unnecessary delays when placing children in homes across state lines.** This provision requires that, no later than October 1, 2027, a state, territory, or tribe operating a title IV-E program include use of an electronic interstate case processing system as part of its procedures for timely placement of children across state lines. Additionally, this section requires HHS to reserve a total of $5 million in any FY2018 discretionary funding provided for the PSSF program for states to use for this purpose. Funding remains available until FY2022. States piloting this system have reported children waited on average of one and a half months less to be placed in the right home, and that they saved substantial amounts on printing and mailing costs alone.

**Section 50723. Enhancements to grants to improve well-being of families affected by substance abuse.** This section requires HHS to continue to award existing competitive "regional partnership grant" funds through FY2021 to provide evidence-based services to prevent child abuse and neglect related to substance abuse, stipulates that partnerships may be established on a statewide basis, and it removes the prohibition on state-agency only partnerships. It also requires that in addition to the state child welfare agency, every funded partnership must include the state agency that administers the federal substance abuse prevention and treatment block grant.

Part III – Miscellaneous

**Section 50731. Reviewing and improving licensing standards for placement in a relative foster family home.** This section requires HHS to identify reputable model standards for licensing foster family homes not later than October 1, 2018. No later than April 1, 2019 each state is required to submit information to HHS on whether its own licensing standards are fully consistent with the model standards identified by HHS, how they take advantage of the flexibility in current law to waive unnecessary requirements for relatives so children can be quickly placed with them instead of in foster care, and if not, why this inconsistency is appropriate for the state.

**Section 50732. Development of a statewide plan to prevent child abuse and neglect fatalities.** This section rewrites the existing state plan requirement to require the state child welfare agency to more fully document the steps it takes to track and prevent child maltreatment deaths, as well as explain how they are implementing a comprehensive plan to deal with this problem.

**Section 50733. Modernizing the title and purpose of title IV-E.** This section changes 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 included in this bill, as well as make other changes to conform underlying law with the new language added by this title.

**Section 50734. Effective dates.** This section contains the effective dates for this title.

Part IV – Ensuring the Necessity of a Placement that Is Not in a Foster Family Home

**Section 50741. Limitation on Federal financial participation for placements that are not in foster family homes.** Under this section, title IV-E foster care maintenance payment supports are not available for more than two weeks for an otherwise eligible child who is placed in a setting that is not a foster family home, unless the placement setting is a—

- "Qualified residential treatment program" (provided additional requirements are met);
- Setting specializing in providing prenatal, postpartum, or parenting supports for youth;
- Supervised independent living setting (provided the child is at least 18 years of age); Licensed residential family-based treatment center (provided the child was placed with the parent and had not been in this setting for more than 12 months); or
- A setting providing high-quality residential care and supportive services to children and youth who have been found to be, or who are at risk of becoming, sex trafficking victims.

A qualified residential treatment program would be required to have nursing and clinical staff on-site in accordance with the needs of the child as specified the child's treatment model. These programs would not have to employ these staff through a direct employer to employee relationship.

This section also clarifies that a state can continue to receive federal reimbursement for administrative expenses associated with overseeing a child placed in foster care, even if the child is placed in a congregate care setting for which the state will no longer receive federal reimbursement.

**Section 50742. Assessment and documentation of the need for placement in a qualified residential treatment program.** For any child placed in a "qualified residential treatment program," this provision would require states to have additional case review procedures as follows:

- Assessment and determination by qualified individual within 30 days of placement;
- Assemble a "Family and Permanency Team" to work with the qualified individual on placement assessment;
- Court approval or disapproval of placement determination within 60 days of placement;
- Ongoing review of placement setting decision by state agency; and
- Additional oversight for stays beyond specified time periods.

This section also states that children should be placed with their siblings unless there is a finding by the court that such placement is contrary to their best interest, as well as requires the individual conducting the assessment to justify a different placement recommendation if they recommend something different than what the family and permanency team and child prefer.

**Section 50743. Protocols to prevent inappropriate diagnoses.** This section requires states to include in their plan the state's established procedures to ensure children are not inappropriately placed in a non-family setting, due to an inappropriate diagnosis of mental illness, behavioral disorders, medically fragile conditions, or developmental disabilities.

**Section 50744. Additional data and reports regarding children placed in a setting that is not a foster family home.** This section rewrites the existing reporting requirement to list more types of non-foster family home settings for which specific information must be included in the report and would additionally request 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 50745. Criminal records checks and checks of child abuse and neglect registries for adults working in child-care institutions and other group care settings.** This section requires states to conduct background checks of residential facility staff, specifically fingerprint-based checks of national crime information databases and checks of state child abuse registries, unless the state reports alternate checks they conduct and why these two checks aren't appropriate for the state.

**Section 50746. Effective dates; application to waivers.** This section specifies the effective dates of sections in this title. This section also allows states to delay, at their sole discretion for up to two years, changes to federal reimbursement for group home placements, giving states more time to adapt to this change. States electing to delay these changes would also delay their receipt of federal funds for prevention services by the same length of time.

Part V – Continuing Support for Child and Family Services

**Section 50751. Supporting and retaining foster families for children.** This section provides services designed to support and retain foster families so they can provide quality family-based settings for children in foster care. It provides an appropriation of $8 million in FY2018 for HHS to make competitive grants to states or tribes to support recruitment and retention of high-quality foster families.

**Section 50752. Extension of child and family services programs.** This section extends this same annual level of discretionary and mandatory funding authority for the Child Welfare Services program and the Promoting Safe and Stable Families program through FY2021. This section also extends the entitlement of eligible state highest courts to Court Improvement Program grant funding through FY2021.

**Section 50753. Improvements to the John H. Chafee foster care independence program and related provisions.** This section permits states to certify that they use CFCIP funds to serve youth who have aged out of foster care and are not yet 23 years of age but only if the HHS Secretary determines that the state has elected to extend federal title IV–E foster care to children up to age 21; or that the state provides comparable assistance with state or other non-title IV–E funds. It permits HHS to redistribute any CFCIP or Education and Training funds that are not spent within the two-year time frame to one or more states (including tribes) that apply for these funds.

Part VI – Continuing Incentives to States to Promote Adoption and Legal Guardianship

**Section 50761. Reauthorizing adoption and legal guardianship incentive programs.** This section continues state eligibility to earn these incentive payments and extends annual discretionary funding authority at the current law level of $43 million per year through FY2022.

Part VII – Technical Corrections

**Section 50771. Technical corrections to data exchange standards to improve program coordination.** This section rewrites these current-law provisions to require HHS 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 applicable federal law.

**Section 50772. Technical corrections to State requirement to address the developmental needs of young children.** This section clarifies that a state must describe in its title IV-B Child Welfare Services plan what it is doing to address the developmental needs of all vulnerable children under five 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).

Part VIII – Ensuring States Reinvest Savings Resulting from Increase in Adoption Assistance

**Section 50781. Delay of adoption assistance phase-in.** States can receive partial reimbursement from the title IV-E adoption assistance program for payments to families who adopt children from foster care (who meet certain requirements) who came from low-income households. The Fostering Connections to Success and Increasing Adoptions Act of 2008 began phasing out the income requirement by age, so after 10 years states would receive partial reimbursement for all children meeting the requirements regardless of the income of the household they were removed from. This provision would delay the final age-related phase out of this income test until July 1, 2024.

**Section 50782. GAO study and report on state reinvestment of savings resulting from increase in adoption assistance.** This section requires the Government Accountability Office (GAO) to study whether states are complying with the requirement that they spend, for child welfare purposes, an amount equal to the amount of savings (if any) resulting from phasing out the income eligibility requirements for federal adoption assistance and the requirement that not less than 30 percent of any such savings be used for post-adoption or post-guardianship services and services to support and sustain positive outcomes, and permanency, for children who might otherwise enter foster care.

## TITLE VIII – SUPPORTING SOCIAL IMPACT PARTNERSHIPS TO PAY FOR RESULTS

**Section 50801. Short title.** This title may be cited as the "Social Impact Partnerships to Pay for Results Act".

**Section 50802. Social impact partnerships to pay for results.** This section provides $100 million for the federal government to pay for outcomes through Social Impact Partnership projects. Under these projects, state and local governments would raise their own money 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.

## TITLE IX – PUBLIC HEALTH PROGRAMS

### Section 50901. Extension for community health centers, the National Health Service Corps, and teaching health centers that operate GME programs.

*Community Health Centers*

This section extends and increases mandatory funding for community health centers (CHCs) from $3.6 billion per year to $3.8 billion for FY2018 and $4 billion for FY2019. (Note: $550 million was provided for the first and second quarters of FY2018 in Public Law 115-96). It also authorizes the Secretary of Health and Human Services (HHS) to award supplemental grants to health centers for implementing evidence-based models that increase access to high-quality primary care. These models could include improving the delivery of care for individuals with multiple chronic conditions, expanding the use of telehealth and other technologies, integrating behavioral health into primary care, and others.

This section prioritizes funding to areas of greatest need by:

- Providing for special consideration of supplemental funding for grant applications that seek to address significant barriers to care;
- Providing for special consideration of expanded service applications that seek to address emerging public health, behavioral health, mental health, or substance use issues;
- Prioritizing new access points to areas that have the greatest unmet need; and
- Ensuring that grants to health centers for homeless individuals include those that will focus innovative programs for outreach to and health services for homeless veterans and veterans at risk of homelessness.

This section improves oversight and accountability of funding provided to health centers by ensuring that health centers are collaborating with other health care providers in the area, such as local hospitals and specialty providers, to improve care coordination and reduce unnecessary hospitalizations and emergency department admissions. This section also adds reporting requirements for the Secretary of HHS to include in its report to Congress information on the distribution of funding for new access points and expanded services among rural and urban areas as well as the rate of closure for health centers and access points. It also maintains a House amendment to authorize and appropriate $25 million for FY2018 to support participation of the CHCs in enrolling participants in the Precision Medicine Initiative's All of Us Research Program.

*National Health Service Corps*

This section extends mandatory funding for the National Health Service Corps at the current level of $310 million for each of fiscal years 2018 and 2019. (Note: $65 million was provided for the first and second quarters of FY2018 in Public Law 115-96).

*Teaching Health Center Graduate Medical Education Program*
This section extends and increases funding for the THCGME program from $60 million per year to $126.5 million for each of fiscal years 2018 and 2019. (Note: a total of $30 million was provided for the first and second quarters of FY2018 in Public Laws 115-63 and 115-96). This section also ensures accountability by requiring the Secretary to report to Congress on the number of patients and patient visits treated by residents as well the number of residents who go on to serve in rural areas or health professional shortage areas or medically underserved communities. In addition, this section calls for a report to Congress on the direct and indirect expenses associated with training residents at teaching health centers.

This section updates the statute and directs the Secretary of HHS to support the maintenance of filled positions at existing approved teaching health centers, as well as the expansion of existing or establishment of new such programs, as appropriate. In awarding grants to establish new teaching health centers, this section also directs the Secretary to prioritize qualified teaching health centers that are located in a rural area or serve a health professional shortage area or a medically underserved community.

**Section 50902. Extension for special diabetes programs.** This section extends mandatory funding for the Special Diabetes Program for Type 1 Diabetes at the current level of $150 million for each of fiscal years 2018 and 2019, until expended. (Note: $37.5 million was provided for the first and second quarters of FY2018 in Public Law 115-96).This section also extends mandatory funding for the Special Diabetes Program for Indians at the current level of $150 million for each of fiscal years 2018 and 2019, until expended. (Note: $37.5 million was provided for the first quarter of FY2018 in Public Law 115-63 and an additional $37.5 million was provided for the second quarter of FY2018 in Public Law 115-96).

## TITLE X – MISCELLANEOUS HEALTH CARE POLICIES

**Section 51001. Home health payment reform.** Under current law, Medicare pays for home health services using 60-day units of payment. Payment amounts for these episodes vary based on patient characteristics, such as clinical information and functional status, as well as the amount of therapy provided to the patient. The Centers for Medicare & Medicaid Services (CMS), the Medicare Payment Advisory Commission (MedPAC), and a Senate Finance Committee staff report have warned that including the amount of therapy as a determination of payment provides misaligned incentives and leaves the Medicare Trust fund vulnerable.

This section would reform the home health payment system beginning in 2020. Specifically, this section would reduce the unit of payment of a home health episode from 60 days to 30 days and would require the Secretary to revise the current home health case-mix system. As part of the revised case-mix system, the Secretary would eliminate the use of the therapy thresholds. Subsequent to the implementation of a revised payment system, home health payments would be adjusted as necessary to ensure the revised payment system is budget neutral. In order to provide the public, beneficiaries, and stakeholders greater transparency in the development of a revised case-mix system, this section would require the Secretary to hold at least one session of a technical expert panel to identify and prioritize recommendations for the revised payment

system. Finally, the Secretary would be required to undergo rulemaking to propose and then finalize the revised payment system prior to January 1, 2020.

**Section 51002. Information to satisfy documentation of Medicare eligibility for home health services.** The Patient Protection and Affordable Care Act (PPACA) requires that a certifying physician must conduct a face-to-face encounter with a Medicare beneficiary before he or she attests that the beneficiary is eligible for home health care services. Initially, to fulfill this face-to-face requirement, the Centers for Medicare and Medicaid Services (CMS) required physicians to write a narrative confirming the beneficiary's homebound status and need for skilled services. In order to alleviate provider confusion and burden from this initial requirement, CMS subsequently eliminated the narrative requirement for episodes beginning on or after January 1, 2015. The certifying physician is still required to attest that a face-to-face patient encounter occurred and document it as part of the patient's eligibility certification.

This section would allow CMS to determine if a beneficiary is eligible for Medicare coverage of home health services through a review of the entire patient medical record, including the home health agency's patient record. In places where the physician's record may be insufficient to determine eligibility, the home health agency's record could be used as supporting material to attest eligibility for home health services.

**Section 51003. Technical amendments to Public Law 114-10 (the Medicare Access and CHIP Reauthorization Act).** This section would make technical changes to improve the application of the Merit-based Incentive Payment System (MIPS) that was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). It would (1) limit the application of the performance-based payment adjustment to services paid under the physician payment schedule, consistent with performance incentive programs that were the precursors to MIPS; (2) ensure that the metrics for assessing resource use are relevant and fair; and (3) allow CMS to more gradually raise the threshold on which total performance is assessed. This section would also allow the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback to stakeholders regarding alternative payment models submitted for consideration.

**Section 51004. Expanded access to Medicare intensive cardiac rehabilitation programs.** The section would expand access to intensive cardiac rehabilitation (ICR) programs for beneficiaries with stable, chronic heart failure and any future condition for which cardiac rehabilitation is covered, unless the Secretary determines coverage is not supported by clinical evidence.

**Section 51005. Extension of blended site neutral payment rate for certain long-term care hospital discharges; temporary adjustment to site neutral payment rates.** Beginning in 2016, Congress implemented site neutral payment reforms using specified long-term care hospital (LTCH) patient criteria. Patients who stay three days or more in an Intensive Care Unit (ICU) or patients who require mechanical ventilation services for at least 96 hours receive payment under the LTCH prospective payment system. All other LTCH discharges are paid an amount comparable to Medicare acute inpatient hospital payment system rates or 100 percent of the cost of the case, whichever is lower. These site neutral payments have been phased-in over a two-year period. In both fiscal years 2016 and 2017, LTCH cases that do not meet the specified

patient criteria receive a blended rate that consists of one-half the standard LTCH payment and one-half the site neutral payment. Full implementation of the site neutral payment rate began on October 1, 2017. This section would extend the 50/50 payment blend two additional years through fiscal year 2019. This payment relief would also be fully offset by a 4.6 percent reduction in the LTCH specific IPPS comparable per diem amount.

**Section 51006. Recognition of attending physician assistants as attending physicians to serve hospice patients.** Medicare's hospice benefit was established to provide end-of-life care to beneficiaries who are terminally ill with a life expectancy of six months or less. Hospice care is provided under two 90-day benefit periods and an unlimited number of subsequent 60-day benefit periods. For the first 90-day period of hospice care, the individual's attending physician and the hospice medical director must each certify in writing that the individual is terminally ill with a life expectancy of six months or less. For a subsequent 90-day or 60-day period of hospice care, the hospice medical director must recertify that the individual is terminally ill based on such clinical judgment. Additionally, Medicare requires that a written plan of hospice care has been established for an individual and is periodically reviewed to ensure hospice care is provided pursuant to the plan by the individual's attending physician (or nurse practitioner) and by the medical director of the hospice program. Further, beginning January 1, 2011, a hospice physician or nurse practitioner must have a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th day recertification and each subsequent 60-day recertification for hospice care, and must attest that such visit took place.

This section would permit physician assistants to serve as the attending physician, which allows them to manage and separately bill for hospice care. This section would also enable physician assistants to act as the attending physician to establish, and periodically review, the hospice plan of care to ensure care is provided pursuant to such plan of care. Finally, this section would clarify that, as with nurse practitioners, physician assistants cannot certify or recertify hospice care for individuals.

**Section 51007. Extension of enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2017.** This section would require the HHS Secretary to continue applying, through calendar year 2017, the enforcement instruction providing for an exception to requirements that certain outpatient therapeutic services furnished in critical access hospitals and other small rural hospitals be provided under the direct supervision of a physician in the hospital. Direct supervision, as defined by 42 CFR 410.32, requires a physician or non-physician practitioner to be immediately available to furnish assistance and direction throughout the performance of a procedure.

**Section 51008. Allowing physician assistants, nurse practitioners, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs.** This section would revise the current law requirement that a physician supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs by also allowing a physician assistant, nurse practitioner, or clinical nurse specialist to supervise such programs, beginning January 1, 2024.

**Section 51009. Transitional payment rules for certain radiation therapy services under the physician fee schedule.** This section would extend the requirement that certain radiation therapy services remain at the current payment level through 2019, providing radiation oncologists more time to prepare for a possible alternative payment model.

## TITLE XI – PROTECTING SENIORS' ACCESS TO MEDICARE ACT

**Section 52001. Repeal of the Independent Payment Advisory Board (IPAB).** This section would repeal the Independent Payment Advisory Board that is charged with making recommendations that reduce Medicare spending when per-capita growth exceeds an expenditure growth target. As recommendations from this board of 15 appointed individuals would take effect unless Congress promptly acts to enact its own policies that achieve equivalent spending reduction, repeal of IPAB reaffirms the management of Medicare as fully within the purview of Congress.

## TITLE XII - OFFSETS

**Section 53101. Modifying reductions in Medicaid Disproportionate Share Hospital (DSH) allotments.** Under current law, disproportionate share hospital (DSH) payments are scheduled to be reduced starting in FY2018. This provision would eliminate the DSH reductions in FY2018 and FY2019, maintain the $4 billion in reductions for FY2020, and set the amount of reductions for FY2021 through FY2025 at $8 billion per year.

**Section 53102. Third party liability in Medicaid and CHIP.** This section permanently repeals a provision in the Bipartisan Budget Act of 2013 that would have allowed states to recover medical expense claims from any portion of a Medicaid beneficiary settlement, including money set aside for a beneficiary's future care or living expenses. It also modified Medicaid third-party liability (TPL) rules as it relates to Medicaid payer of last resort requirements. Current law requires states to pay first and seek reimbursement from third parties in some circumstances. This section includes a provision that removes the requirement that states pay providers for prenatal care first before seeking reimbursement by third parties. It also includes a provision to further delay for two years the option for states to delay payment to providers for certain care for children, including Early and Periodic Screening, Diagnostic, and Treatment services, for up to 90 days while seeking reimbursement from third parties. The provision includes a GAO study and report to Congress to examine the effects of these changes. Finally, the section also applies third party liability requirements to CHIP.

**Section 53103. Treatment of lottery winnings and other lump-sum income for purposes of income eligibility under Medicaid.** This section modifies rules related to qualified lottery and gambling winnings for purposes of income calculations when determining eligibility for Medicaid, specifying the period over which such income would be considered.

**Section 53104. Rebate obligation with respect to line extension drugs.** Current law imposes an alternative rebate formula for purposes of the Medicaid Drug Rebate Program for drugs that

are line extensions of certain single source or innovator multiple source drugs. Under current law drafting, this rebate is the basic rebate or the higher of the additional rebate or line extension rebate. This section adjusts current law to clarify that the rebate for line extension drugs is the greater of either the base rebate plus the additional rebate, or the base rebate plus the line extension rebate.

**Section 53105. Medicaid Improvement Fund**. This section would rescind $985 million from the Medicaid Improvement Fund.

**Section 53106. Physician fee schedule update.** This section reduces the update to the Physician Fee Schedule for 2019 from 0.50 percent to 0.25 percent.

**Section 53107. Payment for outpatient physical therapy services and outpatient occupational therapy services furnished by a therapy assistant.** This section would reduce payment for outpatient therapy services furnished entirely or in part by a physical or occupational therapy assistant, bringing the payment rate in line with the 85 percent of the amount Medicare would otherwise pay that typically applies for other services furnished with the assistance of an ancillary professional.

**Section 53108. Reduction for non-emergency end-stage renal disease (ESRD) ambulance transports.** This section would reduce the amount that Medicare would otherwise pay for ambulance transports to and from a dialysis facility in non-emergency situations by 13 percent, in recognition of lower level of readiness associated with these routine, scheduled transports.

**Section 53109. Hospital transfer policy for early discharges to hospice care.** Medicare currently maintains two different hospital transfer polices that adjust inpatient hospital payments for services furnished to beneficiaries who are discharged early. Medicare severity diagnosis related group (MS-DRG) payments are reduced when beneficiaries (1) have a length of stay at least one day less than the geometric mean length of stay for the MS-DRG, and (2) are transferred to another hospital covered by the acute inpatient prospective payment system (IPPS), or (3) are discharged to a post-acute care setting including skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), home health agencies (HHAs), long-term care hospitals (LTCH), and inpatient psychiatric hospitals. Transferring facilities under this policy are paid a per diem rate rather than the full MS-DRG payment consistent with Congressional intent that hospitals should not receive full prospective payments for beneficiaries who are discharged early and subsequently admitted to another clinical setting for additional medical care. In contrast, under current Medicare law, an acute care inpatient hospital payment is not reduced if a beneficiary is discharged early to a hospice program.

This section would establish, beginning on October 1, 2018, a hospital transfer payment policy for early discharges to hospice care. This reform applies the current Medicare hospital transfer payment policy (in effect for early discharges to other hospitals and to post-acute care facilities) to hospitals that discharge Medicare beneficiaries early to hospice care. In a May 2013 report, the HHS Office of the Inspector General (OIG) concluded that enacting a hospital transfer payment policy for early discharges to hospice care "would not cause hospitals a significant financial disadvantage or disproportionately affect any hospital." The OIG report also noted that

"an overwhelming majority of hospital officials stated…that a reduction in hospital payments resulting from a hospice transfer policy would not influence medical practice in a way that increases the health risks for beneficiaries or creates an incentive for hospitals to extend hospital stays."

**Section 53110. Medicare payment update for home health services.** Medicare reimbursement for home health agency (HHA) providers will increase by 1.5 percent in 2020.

**Section 53111. Medicare payment update for skilled nursing facilities.** Medicare reimbursement for skilled nursing facility (SNF) providers will increase by 2.4 percent in fiscal year 2019.

**Section 53112. Preventing the artificial inflation of star ratings after the consolidation of MA plans offered by the same organization.** In recent years, CMS has encouraged MA organizations to consolidate their MA plans into fewer contracts. An unintended consequence of contract consolidation can be an artificial increase in star ratings, and therefore, quality bonus payments. Earlier this year, CMS proposed new rules related to how contract consolidations affect star ratings to more accurately reflect performance of the surviving and consumed contracts. This section would direct CMS to calculate a weighted average of star ratings across contracts that have been consolidated to more accurately reflect quality and mitigate unwarranted quality bonus payments.

**Section 53113. Sunsetting exclusion of biosimilars from Medicare Part D coverage gap discount program.** This section would include biosimilars in the Medicare Part D coverage gap discount program. Specifically, it would require manufacturers of biosimilars to provide a discount to remove the incentive to prescribe a brand reference biologic over the biosimilar. Under the current coverage gap structure, the Part D plan and the beneficiary typically pays more for a biosimilar.

**Section 53114. Adjustments to Medicare part B and part D premium subsidies for higher income individuals.** This section would, starting in 2019, increase the percentage that beneficiaries with a modified adjusted gross income (MAGI) of at least $500,000 ($750,000 for a couple filing jointly) pay in Part B and Part D premiums from 80 percent to 85 percent. It would freeze these this new income threshold through 2028, at which point the threshold would be indexed to inflation.

**Section 53115. Medicare Improvement Fund.** This section would rescind $220 million from the Medicare Improvement Fund.

**Section 53116. Closing the Donut Hole for Seniors.** This section would accelerate the closure of the Part D program coverage gap, the phase known as the "donut hole" where beneficiaries are responsible for a greater portion of their prescription drug costs, with the beneficiary contribution decreasing to 25 percent of prescription costs in 2019, instead of 2020 under current law. In addition, it would increase the percentage that a drug manufacturer must discount the cost of prescriptions in this phase from 50 percent under current law to 70 percent, with the plan responsible for 5 percent, starting in 2019, thus reducing federal spending. The 70 percent

manufacturer discount would continue to count toward beneficiary true out of pocket cost as under current law.

**Section 53117. Modernizing child support enforcement fees.** The Deficit Reduction Act of 2005 required that individuals who have never received Temporary Assistance for Needy Families (TANF) benefits be charged an annual fee of $25 if the state collects more than $500 in child support on their behalf. This provision would update this policy, requiring a fee of $35 if the state collects more than $550 in child support on behalf of an individual.

**Section 53118. Increasing efficiency of prison data reporting.** Current law prohibits Supplemental Security Income (SSI) payments to individuals while they are in prison. To encourage correctional institutions to report this information, institutions that report information on an individual who before confinement received SSI can earn a payment of $400 if they report the individual's information within 30 days, and $200 dollars if this information is reported between 30 and 90 days after. This provision would require the institutions to report information within 15 days to receive a payment of $400.

**Section 53119. Prevention and Public Health Fund.** This section reduces mandatory funding in the Prevention and Public Health Fund (PPHF) by $1.35 billion over the 10 year budget window in order to generate $998 million in savings.