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Health Care-Related Expiring Provisions of the 115th Congress, First Session

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Summary

This report provides descriptions of selected health care-related provisions that are scheduled to expire during the 115th Congress, first session (i.e., during calendar year [CY] 2017). For purposes of this report, *expiring provisions* are defined as portions of law that are time limited and will lapse once a statutory deadline is reached absent further legislative action. The expiring provisions included in this report are those related to Medicare, Medicaid, State Children's Health Insurance Program (CHIP), and private health insurance programs and activities. The report also includes other health care-related provisions that were last extended under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10). Additionally, this report describes health care-related provisions within the same scope that expired during the 114th Congress, second session (i.e., during CY2016). Although the Congressional Research Service (CRS) has attempted to be comprehensive, it cannot guarantee that every relevant provision is included here.

This report generally focuses on two types of health care-related provisions within the scope discussed above. The first type of provision provides or controls mandatory spending, meaning that it provides temporary funding, temporary increases or decreases in funding (e.g., Medicare provider bonus payments), or temporary special protections that may result in changes in funding levels (e.g., Medicare funding provisions that establish a floor). The second type of provision defines the authority of government agencies or other entities to act, usually by authorizing a policy, project, or activity. Such provisions also may temporarily delay the implementation of a regulation, requirement, or deadline, or establish a moratorium on a particular activity. Expiring health care provisions that are predominantly associated with discretionary spending activities—such as discretionary authorizations of appropriations and authorities for discretionary user fees—are excluded from this report.

Certain types of provisions with expiration dates that otherwise would meet the criteria set forth above are excluded from this report. Some of these provisions are excluded because they are transitional or routine in nature or have been superseded by congressional action that otherwise modifies the intent of the expiring provision. For example, statutorily required Medicare payment rate reductions and payment rate re-basings that are implemented over a specified time period are not considered to require the attention of Congress and are excluded.

The report provides tables listing the relevant provisions that are scheduled to expire in 2017 and that expired in 2016. The report then describes each listed provision, including a legislative history. An appendix lists relevant demonstration projects and pilot programs that are scheduled to expire in 2017 and that expired in 2016.

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This report generally focuses on two types of health care-related provisions within the scope discussed above. The first type of provision provides or controls mandatory spending, meaning that it provides temporary funding, temporary increases or decreases in funding (e.g., Medicare provider bonus payments), or temporary special protections that may result in changes in funding levels (e.g., Medicare funding provisions that establish a floor).[2] The second type of provision defines the authority of government agencies or other entities to act, usually by authorizing a policy, project, or activity.[3] Such provisions also may temporarily delay the implementation of a regulation, requirement, or deadline, or establish a moratorium on a particular activity.[4] Expiring health care provisions that are predominantly associated with discretionary spending activities—such as discretionary authorizations of appropriations and authorities for discretionary user fees[5]—are excluded from this report. For example, the Food and Drug Administration medical product user fee programs, which expire on September 30, 2017, are discussed in a separate CRS report.[6]

Certain types of provisions with expiration dates that otherwise would meet the criteria set forth above are excluded from this report. Some of these provisions are excluded because they are transitional or routine in nature or have been superseded by congressional action that otherwise modifies the intent of the expiring provision. For example, statutorily required Medicare payment

[1] No private health insurance provisions met the criteria for inclusion in this report. However, two provisions related to private health insurance that are expiring in 2017 are included. Both provisions modify fees and taxes established by the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) to help fund ACA activities, including those related to private health insurance.

[2] Mandatory spending is controlled by authorization acts; discretionary spending is controlled by appropriations acts. For further information, see CRS Report R44582, *Overview of Funding Mechanisms in the Federal Budget Process, and Selected Examples*.

[3] For further information about these types of authorization provisions, see CRS Report R42098, *Authorization of Appropriations: Procedural and Legal Issues*.

[4] The two provisions included in the report that modify fees and taxes established by the ACA are the exceptions to this general rule.

[5] The Congressional Budget Office is required to compile this information each year under Section 202(e)(3) of the Congressional Budget Act. The most recent report, *Expired and Expiring Authorizations of Appropriations* (January 13, 2017), which includes provisions set to expire as of September 30, 2017, is available at https://www.cbo.gov/publication/52368.

[6] For more information on the 2017 reauthorization cycle of the Food and Drug Administration user fee programs for prescription drugs, medical devices, biologics, and generic drugs, which were last reauthorized by the Food and Drug Administration Safety and Innovation Act of 2012 (FDASIA; P.L. 112-144), see CRS Report R44750, *FDA Medical Product User Fee Reauthorization: In Brief*.

rate reductions and payment rate re-basings that are implemented over a specified time period are not considered to require the attention of Congress and are excluded.

The report is organized as follows: **Table 1**, below, lists the relevant provisions that are scheduled to expire in 2017. **Table 2**, which follows, lists the relevant provisions that expired during 2016. The provisions in each table are organized by expiration date and applicable health care-related program.

The report then provides descriptions of each listed provision, including a legislative history. The summaries are grouped by provisions that are scheduled to expire in 2017 followed by those that expired in 2016.[7] **Appendix A** lists demonstration projects and pilot programs that are scheduled to expire in 2017 or that expired in 2016 and are related to Medicare, Medicaid, CHIP, and private health insurance programs and activities or other health care-related provisions that were last extended under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10). **Appendix B** lists all laws that created, modified, or extended the health care-related expiring provisions described in this report. **Appendix C** lists abbreviations used in the report.

Table 1. Provisions Expiring in the 115th Congress, First Session

(CY2017)

Expires After	Health Care-Related Program	Provision[a]	
June 30, 2017	Medicare	Non-application of Medicare Fee Schedule Adjustments for Wheelchair Accessories	PAMPA §2
September 30, 2017	Medicare	Outreach and Assistance for Low-Income Programs	SSA §§1102 and 1871 42 U.S.C. §1395b–3 note
September 30, 2017	Medicare	Medicare-Dependent Hospital Program	SSA §1886(d)(5)(G) 42 U.S.C. §1395ww(d)(5)(G)
September 30, 2017	Medicare	Low-Volume Adjustment	SSA §1886(d)(12) 42 U.S.C. §1395ww(d)(12)
September 30, 2017	Medicare	Contract with a Consensus-Based Entity Regarding Performance Measurement	SSA §1890(d) 42 U.S.C. §1395aaa
September 30, 2017	Medicare	Quality Measure Selection	SSA §1890A 42 U.S.C. §1395aaa-1
September 30, 2017	Medicare	Delay in Applying the 25% Patient Threshold Payment Adjustment for Long-Term Care Hospitals	MMSEA §114(c) 42 U.S.C. §1395ww note
September 30, 2017	Medicare	Long-Term Care Hospital Moratoria	MMSEA §114(d) 42 U.S.C. §1395ww note

[7] The 2017 expiring provisions are further organized by Social Security Act (SSA) and Public Health Service Act (PHSA) title and section. A third category includes provisions that are freestanding (i.e., statutory authority that does not amend an existing statute).

Expires After	Health Care-Related Program	Provision[a]	
September 30, 2017	Medicaid	Delay in Effective Date for Medicaid Amendments Relating to Beneficiary Liability Settlements	SSA §1902(a)(25) 42 U.S.C. §1396a(a)(25))
September 30, 2017	Medicaid/CHIP	Child Health Quality Measures	SSA §1139A(i) 42 U.S.C. §1320b-9a(i)
September 30, 2017	Medicaid/CHIP	Medicaid and CHIP Express Lane Option	SSA §§1902(e)(13)(A)(i) and 1902(e)(13)(l) 42 U.S.C. §1396a(e)(13)
September 30, 2017	CHIP	CHIP Appropriations	SSA §2104(a) 42 U.S.C. §1397dd(a)
September 30, 2017	CHIP	CHIP Child Enrollment Contingency Funds	SSA §2104(n) 42 U.S.C. §1397dd(n)
September 30, 2017	CHIP	CHIP Qualifying State Option	SSA §2105(g)(4) 42 U.S.C. §1397ee(g)(4)
September 30, 2017	CHIP	CHIP Outreach and Enrollment Grants	SSA §§2113(a)(1) and 2113(g)) 42 U.S.C. §1397mm
September 30, 2017	Other	Family-to-Family Health Information Centers	SSA §501(c) 42 U.S.C. §701(c)(1)(A)(iii)
September 30, 2017	Other	Abstinence Education Grants	SSA §510 42 U.S.C. §710
September 30, 2017	Other	Maternal, Infant, and Early Childhood Home Visiting Program	SSA §511 42 U.S.C. §711
September 30, 2017	Other	Personal Responsibility Education Program	SSA §513 42 U.S.C. §713(f)
September 30, 2017	Other	Community Health Center Fund	PHSA §330 42 U.S.C. §254b-2(b)(1)
September 30, 2017	Other	Special Diabetes Programs	PHSA §§330B and 330C 42 U.S.C. §254c-2(b) and 254c-3(b)
September 30, 2017	Other	National Health Service Corps Appropriations	PHSA §338H 42 U.S.C. §254b-2(b)(2)
September 30, 2017	Other	Teaching Health Centers	PHSA §340H 42 U.S.C. §256h
December 31, 2017	Medicare	Therapy Cap Exceptions Process	SSA §1833(g) 42 U.S.C. §1395l(g)(5)
December 31, 2017	Medicare	Assistance for Rural Ambulance Providers in Low Population Density Areas	SSA §1834(l)(12)(A) 42 U.S.C. §1395m(l)(12)(A)
December 31, 2017	Medicare	Temporary Increase for Ground Ambulance Services	SSA §1834(l)(13)(A) 42 U.S.C. §1395m(l)(13)(A)

Expires After	Health Care-Related Program	Provision[a]	
December 31, 2017	Medicare	Work Geographic Practice Cost Indices Floor	SSA §1848(e)(1) 42 U.S.C. §1395w-4 (e)(1)(E)
December 31, 2017	Medicare	Home Health Prospective Payment System Rural Add-On	SSA §1895 42 U.S.C. §1395fff note
December 31, 2017	Private Health Insurance[b]	Annual Fee on Health Insurance Providers	ACA §9010
December 31, 2017	Private Health Insurance	Excise Tax on Medical Device Manufacturers	26 U.S.C. §4191

Source: Congressional Research Service (CRS).

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148. as amended); CHIP = State Children's Health Insurance Program; MMSEA = Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173); PAMPA = Patient Access and Medicare Protection Act (P.L. 114-115); PHSA= Public Health Service Act; SSA = Social Security Act; U.S.C. = *U.S. Code*.

a. Citations in statute and the U.S.C. are provided where available.

b. No private health insurance provisions met the criteria for inclusion in this report. However, two provisions related to private health insurance that are expiring in 2017 are included. Both provisions modify fees and taxes established by the ACA to help fund ACA activities, including those related to private health insurance.

Table 2. Provisions That Expired in the 114th Congress, Second Session

(CY2016)

Expires After	Health Care-Related Program	Provision[a]	
September 30, 2016	Medicare	Funding to Fight Fraud, Waste, and Abuse	SSA §1817(k)(8) 42 U.S.C. §1395i(k)
December 31, 2016[b]	Medicare	Temporary Exception for Certain Severe Wound Discharges from Certain Long-Term Care Hospitals	SSA §1886(m)(6) 42 U.S.C. §1395ww(m)(6)
December 31, 2016	Medicare	Moratorium on Enforcement of Supervision Requirements in CAHs	P.L. 113-198 §1

Source: Congressional Research Service.

Notes: CAH = Critical Access Hospital; SSA = Social Security Act; U.S.C. = *U.S. Code*.

a. Citations in statute and the U.S.C. are provided where available.

b. The authority for this temporary exception expired for discharges after December 31, 2016. The 21st Century Cures Act (Cures Act; P.L. 114-255**),** Division C, Section 15010 temporarily reinstates, after a lapse period and with some modifications, the exception for certain severe wound long-term care hospital discharges that occur during a long-term care hospital's cost-reporting period beginning during FY2018. (See discussion of provision under "CY2016 Expired Provisions," below, for more detail.)

Social Security Act (SSA) CY2017 Expiring Provisions

Title V: Maternal and Child Health Services Block Grant

Family-to-Family Health Information Centers (SSA §501(c); 42 U.S.C. §701(c)(1)(A)(iii))[8]

Background

The Family-to-Family Health Information Centers program funds family-staffed and family-run centers in the 50 states and the District of Columbia. The Family-to-Family Health Information Centers provide information, education, technical assistance, and peer support to families of children (including youth) with special health care needs and health professionals who serve such families. They also assist in ensuring that families and health professionals are partners in decisionmaking at all levels of care and service delivery. This program is administered by the Health Resources and Services Administration (HRSA).

Relevant Legislation

- The **Deficit Reduction Act of 2005 (DRA;** P.L. 109-171**), Section 6064**, established the Family-to-Family Health Information Centers program and appropriated $3 million for fiscal year (FY) 2007; $4 million for FY2008; and $5 million for FY2009.
- The **Patient Protection and Affordable Care Act (ACA;** P.L. 111-148**, as amended), Section 5507**, appropriated $5 million for each of FY2009 through FY2012.
- The **American Taxpayer Relief Act of 2012 (ATRA;** P.L. 112-240**), Section 624**, appropriated $5 million for FY2013.
- The **Pathway for SGR (Sustainable Growth Rate) Reform Act of 2013 (PSRA;** P.L. 113-67**, Division B), Section 1203**, provided $2.5 million for October 1, 2013, through March 31, 2014.
- The **Protecting Access to Medicare Act of 2014 (PAMA;** P.L. 113-93**), Section 207**, provided $2.5 million for the remainder of FY2014 (from April 1, 2014, to September 30, 2014) and provided $2.5 million for the first half of FY2015 (October 1, 2014, through March 31, 2015).
- **MACRA Section 216** struck the partial funding provided in PAMA and provided full-year funding of $5 million for FY2015. It also provided $5 million for each of FY2016 and FY2017.

Current Status

Appropriated funds for states to create or monitor Family-to-Family Health Information Centers have not been enacted for FY2018 or subsequent fiscal years. Any unused portions of grants for a

[8] Citations in statute and the *U.S. Code* (U.S.C.) are provided where available.

given fiscal year that were awarded to states prior to October 1, 2017, will remain available until expended.

Abstinence Education Grants (SSA §510; 42 U.S.C. §710)

Background

Abstinence Education Grants are formula grants available to states that request funding when applying for the Maternal and Child Health Block Grant funds authorized in SSA Section 501. Funds provided must be used exclusively for teaching abstinence from sexual activity outside of marriage.

Relevant Legislation

- The **Personal Responsibility and Work Opportunity Reconciliation Act of 1996** (**PRWORA**; P.L. 104-193), **Section 912**, established Abstinence Education Grants and appropriated $50 million for each fiscal year, starting in FY1998, through FY2002.
- The **Welfare Reform Extension Act of 2003** (**WREA 2003**; P.L. 108-40), **Section 6**, extended the funding through FY2003.
- P.L. 108-89 **Section 101** extended the funding through March 31, 2004.
- The **Welfare Reform Extension Act of 2004** (**WREA 2004**, P.L. 108-210), **Section 2**, extended the funding through June 30, 2004.
- P.L. 108-262 **Section 2** extended the funding through September 30, 2004.
- P.L. 108-308 **Section 2** extended the funding through March 31, 2005.
- The **Welfare Reform Extension Act of 2005** (**WREA 2005**, P.L. 109-4), **Section 2**, extended the funding through June 30, 2005.
- P.L. 109-19 **Section 2** extended the funding through September 30, 2005.
- P.L. 109-91 **Section 102** extended the funding through December 31, 2005.
- The **Tax Relief and Health Care Act of 2006** (**TRHCA**; P.L. 109-432), **Section 401**, extended the funding through June 30, 2007.
- P.L. 110-48 **Section 1** extended the funding through September 30, 2007.
- P.L. 110-90 **Section 2** extended the funding through December 31, 2007.
- The **Medicare, Medicaid, and SCHIP Extension Act of 2007** (**MMSEA**; P.L. 110-173), **Section 202**, extended the funding through June 30, 2008.
- The **Medicare Improvements for Patients and Providers Act of 2008** (**MIPPA**, P.L. 110-275), **Section 201**, extended the funding through June 30, 2009.
- **ACA Section 2954** appropriated $50 million for each of FY2010 through FY2014.
- **PAMA Section 205** appropriated $50 million for FY2015.
- **MACRA Section 214** appropriated $75 million for each of FY2016 and FY2017.

Current Status

Appropriated funds for Abstinence Education Grants have not been enacted for FY2018 or subsequent fiscal years. The FY2017 appropriations will no longer be available for obligation after September 30, 2017.

Maternal, Infant, and Early Childhood Home Visiting Program (SSA §511; 42 U.S.C. §711)

Background

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program provides grants to states, territories, and tribes for the support of evidence-based early childhood home visiting programs. These programs support in-home visits by health or social service professionals with at-risk families. Program funding also is allocated for research and evaluation (3% of appropriations) and for grants to tribal entities for home visitation services to Indian families (3% of appropriations). This program is collaboratively administered by HRSA and the Administration for Children and Families (ACF).

Relevant Legislation

- **ACA Section 2951** established the MIECHV program and appropriated $100 million for FY2010, $250 million for FY2011, $350 million for FY2012, $400 million for FY2013, and $400 million for FY2014.
- **PAMA Section 209** provided $400 million for the first half of FY2015 (October 1, 2014, through March 31, 2015).
- **MACRA Section 218** extended the availability of the $400 million appropriated under PAMA through all of FY2015 (October 1, 2014, through September 30, 2015). It also provided $400 million for each of FY2016 and FY2017.

Current Status

Appropriated funds for the MIECHV program have not been enacted for FY2018 or subsequent fiscal years. The FY2017 appropriations will no longer be available for new obligations after September 30, 2017. Any unused portions of grants for a given fiscal year that were awarded to states prior to October 1, 2017, will remain available for the second fiscal year after the funds were awarded.

Personal Responsibility Education Program (SSA §513; 42 U.S.C. §713(f))

Background

The Personal Responsibility Education Program (PREP) is primarily a state formula grant program to support evidence-based programs designed to educate adolescents about abstinence, contraception, and adulthood. PREP contains five components: (1) state PREP formula grants; (2) competitive state PREP grants; (3) tribal PREP grants; (4) PREP Innovative Strategies grants to implement innovative youth pregnancy prevention strategies and to target services to high-risk populations; and (5) funding for training, technical assistance, and evaluation.

Relevant Legislation

- **ACA Section 2953** established PREP and appropriated a total of $375 million from FY2010 through FY2014.
- **PAMA Section 206** appropriated $75 million for FY2015.
- **MACRA Section 215** appropriated $75 million for each of FY2016 and FY2017.

Current Status

Appropriated funds for PREP have not been enacted for FY2018 or subsequent fiscal years. However, funds appropriated prior to FY2018 are available until expended. States are eligible to receive state PREP formula grants for five years in annual allotments. A state's annual allotment remains expendable by the state through the end of the second fiscal year after the funds are allotted. The Secretary of the Department of Health and Human Services (HHS) has the authority to repurpose funds that were not awarded to states and funds that were not expended during the two-year time frame for the awarding of three-year discretionary competitive state PREP grants.

Title XI: General Provisions, Peer Review, and Administrative Simplification

Outreach and Assistance for Low-Income Programs (SSA §§1102 and 1871; 42 U.S.C. §1395b-3 note)

Background

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90; P.L. 101-508), Section 4359, required the HHS Secretary to establish a "beneficiary assistance program" to help Medicare beneficiaries receive Medicare, Medicaid, and other health-insurance services. The beneficiary assistance program was to provide information and counseling to beneficiaries through local federal offices, community outreach programs, and toll-free telephone services. The beneficiary assistance program was later renamed the State Health Insurance Assistance Program (SHIP).

In OBRA 90 Section 4360, Congress appropriated $10 million annually for FY1991-FY1993 from the Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds for grants to be awarded to states to implement SHIPs. [9] Congress subsequently extended SHIP appropriations.

In addition to SHIPs, the Centers for Medicare & Medicaid Services (CMS) received assistance in conducting outreach, particularly to low-income Medicare beneficiaries, from programs operated by other HHS divisions, such as the Administration for Community Living (ACL), established in 2012. Among other activities, ACL administers federal grant programs that fund Area Agencies on Aging (AAA), Aging and Disability Resource Centers (ADRCs), and the contract with the National Center for Benefits and Outreach Enrollment as well as coordination and outreach activities conducted by the Administration on Aging, a precursor agency to ACL.

[9] Medicare has two trust funds, the Hospital Insurance (HI) Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund. The HI Trust Fund covers Medicare Part A services, including hospital, home health, skilled nursing facility, and hospice care. The SMI Trust Fund covers Medicare Parts B and D, including physician and outpatient hospital services and outpatient prescription drugs.

Congress makes annual appropriations to ACL programs. Since 2014, these appropriations have included funds for SHIPs, now administered by ACL.

Relevant Legislation

- **MIPPA Section 119** authorized and appropriated a total of $25 million for FY2009 to fund low-income Medicare beneficiary outreach and education activities through SHIPs, AAAs, ADRCs, and coordination efforts to inform older Americans about benefits available under federal and state programs.
- **ACA Section 3306** extended MIPPA Section 119 authority for these programs and appropriated a total of $45 million for FY2010 through FY2012 in the following amounts: SHIPs, $15 million; AAAs, $15 million; ADRCs, $10 million; and the contract with the National Center for Benefits and Outreach Enrollment, $5 million.
- **ATRA Section 610** extended authority for these programs through FY2013 and appropriated a total of $25 million in the following amounts: SHIPs, $7.5 million; AAAs, $7.5 million; ADRCs, $5 million; and the contract with the National Center for Benefits and Outreach Enrollment, $5 million.
- **PSRA Section 1110**, extended authority for these programs through the second quarter of FY2014 and appropriated funds at FY2013 levels ($25 million) for the first two quarters of FY2014 (through March 31, 2014).
- **PAMA Section 110** extended authority for these programs through the second quarter of FY2015 (through March 31, 2015). For FY2014, PAMA appropriated a total of $25 million at the following FY2013 funding levels: SHIPs, $7.5 million; AAAs, $7.5 million; ADRCs, $5.0 million; and the contract with the National Center for Benefits and Outreach Enrollment, $5.0 million. In addition, PAMA appropriated funds at FY2014 levels for the first two quarters of FY2015 (through March 31, 2015).
- **MACRA Section 208** extended authority for these programs through September 30, 2017. For FY2015, MACRA provided funding at the previous year's level of $25 million in the following amounts: SHIPs, $7.5 million; AAAs, $7.5 million; ADRCs, $5 million; and the contract with the National Center for Benefits and Outreach Enrollment, $5 million. For FY2016 and FY2017, MACRA appropriated $37.5 million annually, a $12.5 million per year increase from FY2015 funding levels, in the following amounts: SHIPs, $13 million; AAAs, $7.5 million; ADRCs, $5 million; and the contract with the National Center for Benefits and Outreach Enrollment, $12 million.

Current Status

Funding authorized under MACRA for low-income outreach and assistance programs has not been enacted for FY2018 or subsequent fiscal years. However, funds appropriated prior to FY2018 will be available for obligation until expended.

Child Health Quality Measures (SSA §1139A(i); 42 U.S.C. §1320b-9a(i))

Background

SSA Section 1139A established several requirements relating to child health quality measurement. The HHS Secretary was required to publish, and regularly update, a core set of child quality measures that may be used for reporting by states for Medicaid, CHIP and other programs administered under SSA Titles XIX and XXI. The section established the Pediatric Quality Measures Program (PQMP), which currently includes seven Centers of Excellence that work to identify and fill pediatric measure gaps. States are required to submit reports to the Secretary annually on children's health care quality, and the Secretary is required to collect, analyze, and make publicly available the information reported by states. The section also established a grant program for demonstration projects to evaluate ideas to improve the quality of children's health care.

Relevant Legislation

- The **Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA;** P.L. 111-3**), Section 401**, established the child health quality measure-related requirements and appropriated $45 million for each of FY2009 through FY2013 to carry out the activities under SSA Section 1139A, excluding Section 1139A(e) (the childhood obesity demonstration project).
- **PAMA Section 210** extended funding for SSA Section 1139A(b) (the PQMP) for the remainder of FY2014 (from April 1, 2014, to September 30, 2014) by requiring that $15 million of the $60 million appropriated under SSA Section 1139B(e) (Medicaid adult quality measures) be used to carry out SSA Section 1139A(b).
- **MACRA Section 304(b)** appropriated $20 million for the period FY2016-FY2017 for the purposes of carrying out SSA Section 1139A. This funding is specifically excluded from being used to carry out the activities under SSA Section 1139A(e) (the childhood obesity demonstration project); SSA Section 1139A(f) (the development of a model electronic health record for children); and SSA Section 1139A(g) (the Institute of Medicine study of pediatric health quality).

Current Status

Appropriated funds to carry out the child health quality measure activities in this section have not been enacted for FY2018 or subsequent fiscal years. The funds appropriated for FY2017 will no longer be available for obligation after September 30, 2017.

Title XVIII: Medicare

Therapy Cap Exceptions Process (SSA §1833(g); 42 U.S.C §1395l(g)(5))

Background

Medicare beneficiaries face two annual payment limits for all Medicare-covered outpatient therapy services. Established by the Balanced Budget Act of 1997 (BBA 97; P.L. 105-33), these limits initially applied to therapy services provided by nonhospital providers, to be applied

separately for (1) physical therapy services and speech-language pathology services and (2) occupational therapy services. Initially set at $1,500 to apply beginning in 1999, these limits were suspended from 2000 to 2005. DRA re-implemented the limits and added an exceptions process in 2006. Should payments for therapy services furnished during a calendar year exceed the therapy caps, the exceptions process allows providers and practitioners to request an exception on a beneficiary's behalf when those services are reasonable and necessary. A series of subsequent legislative acts has extended the exceptions process, increased the limits, and modified the conditions for the application of the caps each year since.

Relevant Legislation

- **DRA Section 5107** re-implemented the payment limits beginning in 2006 and required the HHS Secretary to implement an exceptions process for services meeting specified criteria for medically necessary services.
- Subsequent legislation (**TRHCA Section 201**; **MMSEA Section 105**; **MIPAA Section 141**; **ACA Section 3103**; the **Medicare and Medicaid Extenders Act of 2010 [MMEA**; P.L. 111-309**]**, **Section 104**; and the **Temporary Payroll Tax Cut Continuation Act of 2011 [TPTCCA**; P.L. 112-78**]**, **Section 304)** extended the exceptions process from CY2007 through February 2012.
- The **Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA;** P.L. 112-96**), Section 3005**, extended the exceptions process through December 2012 and set the annual threshold at $3,700, to be applied separately for the two categories of therapy services effective October 1, 2012. This increased amount applied to therapy services received both in physicians' offices and in hospital outpatient departments for the first time. MCTRJCA also added the requirement that Medicare perform manual medical review of therapy services for which an exception is requested when the beneficiary has reached the dollar aggregate threshold amount.
- **ATRA Section 603** extended the application of the cap and threshold to therapy services furnished in a hospital outpatient department and in a critical access hospital. ATRA Section 603 also extended the mandate that Medicare perform manual medical review of therapy services for which an exception is requested.
- **PSRA Section 1103** and **PAMA Section 103** extended the therapy cap exceptions process through March 31, 2015.
- **MACRA Section 202** extended the exceptions process through December 31, 2017, and required the HHS Secretary to implement a new medical review process for outpatient therapy services. In determining which therapy services to review, the Secretary shall identify services furnished by a therapy provider who (1) has had a high claims-denial percentage or is less compliant with applicable Medicare program requirements; (2) has a pattern of billing for therapy services that is aberrant compared to peers or otherwise has questionable billing practices, such as billing medically unlikely units of services in a day; (3) is newly enrolled or has not previously furnished therapy services under the Medicare program; (4) provides services to treat a type of medical condition; or (5) is part of a group that includes another therapy provider identified by the preceding factors.

Current Status

The authority for the therapy caps exceptions process will expire after December 31, 2017.

Assistance for Rural Ambulance Providers in Low Population Density Areas (SSA §1834(l)(12)(A); 42 U.S.C. §1395m(l)(12)(A))

Background

The SSA provides for Medicare bonus payments for ground ambulance services that originate in qualified rural areas (called *super-rural areas*) furnished on or after July 1, 2004, and before January 1, 2018. Super-rural areas are areas that represent the lowest quartile of population density. CMS estimated and set the super-rural bonus as a 22.6% increase in the base rate for the transport.

Relevant Legislation

- **Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA;** P.L. 108-173**), Section 414(c)**, provided an increase in base payments for ground ambulance services furnished in low population density rural areas beginning July 1, 2004, and ending December 31, 2009. CMS established this increase as 22.6%.
- **ACA Section 3105** extended increased base payments in low population density areas through CY2010 (super-rural ambulance payments).
- **MMEA Section 106** extended the super-rural ambulance payments through CY2011.
- **TPTCCA Section 306** extended the super-rural ambulance payments until March 1, 2012.
- **MCTRJCA Section 3007** extended the super-rural ambulance payments until January 1, 2013.
- **ATRA Section 604** extended the super-rural ambulance payments until January 1, 2014.
- **PSRA Section 1104(b)** extended the super-rural ambulance payments until March 31, 2014.
- **PAMA Section 104(b)** extended the super-rural ambulance payments until March 31, 2015.
- **MACRA Section 203(b)** extended the super-rural ambulance payments until December 31, 2017.

Current Status

The authority for the super-rural ambulance add-on payment will expire after December 31, 2017.

Temporary Increase for Ground Ambulance Services (SSA §1834(l)(13)(A); 42 U.S.C. §1395m(l)(13)(A))

Background

The SSA provides for a temporary increase in the Medicare ambulance fee schedule rates for ground ambulance services that otherwise are established for the year. For transports originating in a rural area, the payment increase is in addition to the super-rural add-on payment.

Relevant Legislation

- **MMA Section 414(d)** provided that the Medicare ambulance fee schedule rates for ground ambulance services otherwise established for the year would be increased an additional 2% for rural ambulance services and 1% for urban ambulance services beginning July 1, 2004, through December 31, 2006.
- **MIPPA Section 146** provided that the rate otherwise established for the year would be increased an additional 3% for rural ambulance services and 2% for other areas for the period July 1, 2008, through December 31, 2009.
- **ACA Section 3105** extended the MIPPA payment increases through CY2010.
- **MMEA Section 106** extended the MIPPA payment increases through CY2011.
- **TPTCCA Section 306** extended the MIPPA payment increases until March 1, 2012.
- **MCTRJCA Section 3007** extended the MIPPA payment increases until January 1, 2013, and required the Government Accountability Office (GAO) to update the report GAO-07-383, *Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly*, by October 1, 2012.[10] MCTRJCA Section 3007 also required the Medicare Payment Advisory Commission (MedPAC) to study the appropriateness of ambulance add-on payments and submit a report to the congressional committees with jurisdiction over Medicare by June 15, 2013. In its November 1, 2012, meeting, MedPAC commissioners voted to recommend that the ambulance add-on payments not be extended. This recommendation (and others concerning Medicare's ambulance payments) was included in MedPAC's June 2013 report to Congress.
- **ATRA Section 604** extended the 2% urban add-on payment and the 3% rural add-on payment until January 1, 2014, and required HHS to study existing cost reports for ambulance services furnished by hospitals and critical access hospitals and the feasibility of obtaining cost data on a periodic basis to assess the appropriateness of ambulance add-on payments. The HHS study concluded that existing cost reports are not an effective approach to collect data to inform ambulance payment policy due to numerous limitations of such data. HHS also concluded that although it is technically feasible to collect more complete and detailed cost data on a periodic basis, it would be difficult to develop a standard cost-reporting tool given the wide variety of characteristics of ambulance providers and suppliers.[11]
- **PSRA Section 1104(a)** extended the MIPPA payment increases until March 31, 2014.
- **PAMA Section 104(a)** extended the MIPPA payment increases through March 31, 2015.

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[10] See U.S. Government Accountability Office, *Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly*, GAO-07-383, May 23, 2007, at http://www.gao.gov/new.items/d07383.pdf, and U.S. Government Accountability Office, *Ambulance Providers: Costs and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased*, GAO 13-6, October 1, 2012, at http://www.gao.gov/assets/650/649018.pdf.

[11] See U.S. Department of Health and Human Services, *Report to Congress: Evaluations of Hospitals' Ambulance Data on Medicare Cost Reports and Feasibility of Obtaining Cost Data from All Ambulance Providers and Suppliers, as Required by the American Taxpayer Relief Act of 2012*, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Downloads/Report-To-Congress-September-2015.pdf.

- **MACRA Section 203(a)** extended the MIPPA payment increases through December 31, 2017.

Current Status

The temporary payment increases to Medicare's ambulance fee schedule for rural and urban ground ambulance transports will expire after December 31, 2017.

Work Geographic Practice Cost Indices Floor (SSA §1848(e)(1); 42 U.S.C. §1395w-4(e)(1)(E))

Background

Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. The Medicare physician fee schedule (MPFS) is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indices—known as Geographic Practice Cost Indices (GPCIs)—that reflect how each area compares to the national average in a "market basket" of goods. A value of 1.00 represents the average across all areas. These indices are used to calculate the payment rate under the MPFS.

Relevant Legislation

- **MMA Section 412** provided for an increase in the work geographic index to 1.0 (floor) for any locality for which the work geographic index was less than 1.0 for services furnished from January 1, 2004, through December 31, 2006.
- **TRHCA Section 102** extended the floor through CY2007.
- **MMSEA Section 103** extended the floor through June 30, 2008.
- **MIPPA Section 134** extended the floor through December 2009. In addition, beginning January 1, 2009, MIPAA set the work geographic index for Alaska to 1.5 if the index otherwise would be less than 1.5; no expiration was set for this modification.
- **ACA Section 3102** extended the floor through December 31, 2010.
- **MMEA Section 103** extended the floor through December 31, 2011.
- **TPTCCA Section 303** extended the floor through February 29, 2012.
- **MCTRJCA Section 3004** extended the floor through December 31, 2012 and required MedPAC to report on whether any work geographic adjustment to the MPFS is appropriate, what that level of adjustment should be (if appropriate), and where the adjustment should be applied. The report also was required to assess the impact of such an adjustment, including how it would affect access to care.
- **ATRA Section 602** extended the floor through December 31, 2013.
- **PAMA Section 102** extended the floor through March 31, 2015.
- **MACRA Section 201** extended the floor through December 31, 2017.

Current Status

The authority for the MPFS GPCI floor will expire after December 31, 2017.

Medicare-Dependent Hospital Program (SSA §1886(d)(5)(G); 42 U.S.C. §1395ww(d)(5)(G))

Background

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239, Section 6003(f)(1)) established criteria and payment for Medicare-dependent hospitals (MDHs) for the period April 1, 1990, through March 31, 1993. MDHs are small, rural hospitals with a high proportion of patients who are Medicare beneficiaries. MDHs receive special treatment, including higher payments, under the Medicare Inpatient Prospective Payment System (IPPS). To be eligible for the MDH program, hospitals must have no more than 100 beds and at least 60% of their acute inpatient days or discharges must be attributable to Medicare in FY1987 or in two of the three most recently audited cost-reporting periods.

Relevant Legislation

- **BBA 97 Section 4204** reinstated the MDH classification, starting on October 1, 1997, through October 1, 2001, for small, rural hospitals that treat a relatively high proportion of Medicare patients, allowing these hospitals to continue to receive special Medicare payments.
- The **Balanced Budget Refinement Act of 1999 (BBRA 99;** P.L. 106-133**), Section 404**, extended the MDH program through September 30, 2006.
- **DRA Section 5003** extended the MDH program through September 30, 2011. Also, effective for discharges on or after October 1, 2006, DRA added FY2002 as an allowable year for purposes of constructing an MDH's base payment rate, increased the MDH payment, and removed the 12% cap on the Medicare disproportionate share hospital (DSH) payment adjustment for MDHs that qualify for DSH.
- **ACA Section 3124** extended the MDH program until September 30, 2012.
- **ATRA Section 606** extended the MDH program until September 30, 2013.
- **PSRA Section 1106** extended the MDH program until March 31, 2014.
- **PAMA Section 106** extended the MDH program until March 31, 2015.
- **MACRA Section 205** extended the MDH program until September 30, 2017.

Current Status

The authority for the MDH program will expire after September 30, 2017.

Low-Volume Adjustment (SSA §1886(d)(12); 42 U.S.C. §1395ww(d)(12))

Background

Under the Medicare IPPS, qualifying hospitals receive increased payments to account for the higher incremental costs associated with a low volume of discharges. The HHS Secretary is required to determine an empirically appropriate percentage increase per discharge, up to a

ceiling of 25%, for low-volume hospitals more than 25 road miles from an acute-care hospital. These hospitals could have as many as 800 total discharges. Based on its analysis, CMS determined that hospitals that have fewer than 200 total (Medicare and non-Medicare) discharges and that are located more than 25 road miles from another acute-care hospital qualified for a 25% increase per discharge.

Relevant Legislation

- **ACA Section 3125, as modified by Section 10314**, eased the distance and volume requirements for hospitals to qualify for the low-volume adjustment and receive increased Medicare IPPS payments for FY2011 and FY2012. The low-volume standards were changed from no more than 800 *total* discharges and more than 25 road miles from another acute-care hospital to no more than 1,600 *Medicare* discharges and more than 15 road miles from another acute-care hospital. Under the enhanced adjustment, qualifying hospitals with 200 or fewer Medicare discharges receive a payment increase of 25% per discharge; the low-volume percentage adjustment diminishes to no increase for hospitals with 1,600 or more Medicare discharges.
- **ATRA Section 605** extended the enhanced low-volume adjustment for FY2013.
- **PSRA Section 1105** extended the enhanced low-volume adjustment through March 31, 2014.
- **PAMA Section 105** extended the enhanced low-volume adjustment through March 31, 2015.
- **MACRA Section 204** extended the enhanced low-volume adjustment through September 30, 2017.

Current Status

The authority for the enhanced low-volume adjustment will revert to the original standards starting for discharges after September 30, 2017. The original standards are set in statute at less than 800 discharges and more than 25 road miles from another acute-care hospital.

Contract with a Consensus-Based Entity Regarding Performance Measurement (SSA §1890(d); 42 U.S.C. §1395aaa)

Background

Under SSA Section 1890, the HHS Secretary is required to have a contract with a consensus-based entity (e.g., National Quality Forum, or NQF) to carry out specified duties related to performance improvement and measurement. These duties include, among others, priority setting, measure endorsement, measure maintenance, and annual reporting to Congress.

Relevant Legislation

- **MIPPA Section 183** transferred, from the Medicare HI and SMI Trust Funds, a total of $10 million for each of FY2009 through FY2012 to carry out the activities under SSA Section 1890.
- **ATRA Section 609(a)** extended funding through FY2013 and modified the duties of the consensus-based entity.

- **PSRA Section 1109** required that transferred funding remain available until expended.
- **PAMA Section 109** transferred $5 million for the remainder of FY2014 (from April 1, 2014, to September 30, 2014) and $15 million for the first six months of FY2015 (from October 1, 2014, to March 31, 2015) to carry out both SSA Section 1890 and SSA Section 1890A(a)-(d); funds were required to remain available until expended.
- **MACRA Section 207** transferred $30 million for each of FY2015 through FY2017 to carry out both SSA Section 1890 and SSA Section 1890A(a)-(d). The funding appropriated under MACRA for FY2015 effectively replaced the funding appropriated under PAMA for that year; therefore, the total funding for FY2015 was $30 million. Funds were required to remain available until expended.

Current Status

Appropriated funds to support the contract with the consensus-based entity in this section have not been enacted for FY2018 or subsequent fiscal years. However, funds appropriated prior to FY2018 are available for obligation until expended.

Quality Measure Selection (SSA §1890A; 42 U.S.C. §1395aaa-1)

Background

SSA Section 1890A requires the HHS Secretary to establish a pre-rulemaking process to select quality measures for use in the Medicare program. The consensus-based entity with a contract gathers multi-stakeholder input and annually transmits that input to the Secretary. The Secretary makes available to the public measures under consideration for use in Medicare quality programs and broadly disseminates the quality measures that are selected to be used. Through its Measure Applications Partnership (MAP), the NQF has been convening multi-stakeholder groups to provide input into the selection of quality measures for use in Medicare and other federal programs. MAP publishes annual reports with recommendations for selection of quality measures in February of each year, with the first report published in February 2012.

Relevant Legislation

- **ACA Section 3014(c)** transferred a total of $20 million from the Medicare HI and SMI Trust Funds for each of FY2010 through FY2014 to carry out SSA Section 1890A(a)-(d) (and the amendments made to SSA Section 1890(b) by ACA Section 3014(a)).
- **PAMA Section 109** transferred $5 million for the remainder of FY2014 (from April 1, 2014, to September 30, 2014) and $15 million for the first six months of FY2015 (from October 1, 2014, to March 31, 2015) to carry out both SSA Section 1890 and SSA Section 1890A(a)-(d); funds were required to remain available until expended.
- **MACRA Section 207** transferred $30 million for each of FY2015 through FY2017 to carry out both SSA Section 1890 and SSA Section 1890A(a)-(d). The funding appropriated under MACRA for FY2015 replaced the funding appropriated under PAMA for that year; therefore, the total funding for FY2015 was $30 million.

Current Status

Appropriated funds to carry out the measure selection activities in this section have not been enacted for FY2018 or subsequent fiscal years. However, funds appropriated prior to FY2018 are available for obligation until expended.

Home Health Prospective Payment System Rural Add-On (SSA §1895; 42 U.S.C. §1395fff note)

Background

Medicare provides increased payments under the home health (HH) prospective payment system (PPS) for home health care provided to beneficiaries in rural areas.

Relevant Legislation

- **The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000;** P.L. 106-554**), Section 508**, established a 10% increase to Medicare's HH PPS rates for home health care provided to beneficiaries in rural areas beginning April 1, 2001, through March 31, 2003.
- **MMA Section 421** provided a 5% increase to Medicare's HH PPS rates for home health care services provided to beneficiaries in rural areas beginning April 1, 2004, through March 31, 2005.
- **DRA Section 5201** reestablished the Medicare HH PPS rural add-on in MMA as a 5% increase beginning January 1, 2006, through December 31, 2006.
- **ACA Section 3131** reestablished the Medicare HH PPS rural add-on in MMA as a 3% increase beginning April 1, 2010, through December 31, 2015.
- **MACRA Section 210** extended the 3% Medicare HH PPS rural add-on through December 31, 2017.

Current Status

The authority for the Medicare HH PPS rural add-on will expire after December 31, 2017.

Other Medicare Provisions[12]

Delay in Applying the 25% Patient Threshold Payment Adjustment for Long-Term Care Hospitals (MMSEA §114(c); 42 U.S.C. §1395ww note)

Background

Long-term care hospitals (LTCHs) generally treat patients who have been discharged from acute-care hospitals but require prolonged inpatient hospital care due to the patients' medical conditions. LTCH patients have an average length of inpatient stay longer than 25 days. LTCHs can be (1) freestanding—a hospital that in general is not integrated with any other hospital; (2)

[12] The provisions in this subsection apply to Medicare but are freestanding and do not amend the SSA.

colocated with another hospital, either located in the same building as another hospital or in a separate building on the hospital's campus; or (3) a satellite facility of an LTCH, a facility that operates as part of the LTCH but in a separate location (which may be colocated with another hospital).

Beginning in FY2005, CMS implemented a new Medicare payment regulation for LTCHs that are colocated with other hospitals and LTCH satellite facilities to limit inappropriate patient shifting driven by financial rather than clinical considerations. Under this policy, if such an LTCH received more than 25% of its Medicare patients from any single referring hospital, the LTCH would be reimbursed the lower of the LTCH PPS or the IPPS reimbursement for discharges that exceeded the threshold. (See next provision for background on the LTCH PPS.) Beginning in FY2008, CMS expanded the 25% patient threshold adjustment policy to include all LTCHs.

Relevant Legislation

- **MMSEA Section 114(c)(1)** delayed the application of CMS's 25% patient threshold adjustment for freestanding LTCHs and "grandfathered hospitals-within-hospitals" LTCHs for three years from the enactment of MMSEA (December 29, 2007). MMSEA Section 114(c)(2) delayed the application of CMS's 25% patient threshold adjustment for LTCHs or satellite facilities colocated with another hospital if (1) LTCHs or satellite facilities located in a rural area or colocated with an urban single or Metropolitan Statistical Area (MSA) dominant hospital receive no more than 75% of their Medicare inpatients from such colocated hospitals or (2) other LTCHs or satellite facilities colocated with another hospital receive no more than 50% of their Medicare inpatients from such colocated hospitals.
- The **American Recovery and Reinvestment Act of 2009 (ARRA;** P.L. 111-5**), Section 4302(a)** modified the beginning of the delays in MMSEA Sections 114(c)(1) and 114(c)(2) from the date of enactment of MMSEA (December 29, 2007) to July 1, 2007. This section also modified the end date for the delay under MMSEA Section 114(c)(2) (LTCHs colocated with another hospital) from three years from the date of enactment to three years from October 1, 2007 (or July 1, 2007, in the case of a satellite facility described in 42 C.F.R. §412.22(h)(3)(i)). In addition, ARRA Section 4302(a) modified the delay under MMSEA Section 114(c)(1) to include LTCHs or satellite facilities that, as of the date of enactment under MMSEA, were colocated with a provider-based off-campus location of an IPPS hospital that did not provide services payable under the IPPS at the off-campus location.
- **ACA Section 3106** extended the delay of the 25% patient threshold adjustment two additional years.
- **PSRA Section 1206(b)(1)** extended the delay of the 25% patient threshold adjustment four additional years to expire after June 30, 2016 (or after September 30, 2016, for certain LTCHs colocated with another hospital).
- **The 21st Century Cures Act (Cures Act;** P.L. 114-255**), Division C, Section 15006** delayed the 25% patient threshold adjustment for discharges occurring October 1, 2016, through September 30, 2017. This provision reinstated the PSRA delay that expired after June 30, 2016 (and extended the PSRA delay that expired after September 30, 2016, for certain LTCHs colocated with another hospital).

Current Status

The delay in CMS applying the 25% patient threshold adjustment to LTCHs expires after September 30, 2017.

Long-Term Care Hospital Moratoria (MMSEA §114(d); 42 U.S.C. §1395ww note)

Background

Under Medicare, LTCHs were exempt from the IPPS when it was established in 1983. Instead, LTCHs were reimbursed on a reasonable-cost basis subject to certain limits established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA; P.L. 97-248). Under the BBRA 99, the LTCH PPS was established, which would provide a per-discharge reimbursement based on the average costs and patient mix of LTCHs. The LTCH PPS typically provides higher Medicare reimbursement rates for inpatient hospital care than the IPPS.

The rapid increase in both the number of LTCHs and LTCH reimbursement led to enactment of a moratorium on the development of new LTCHs and a moratorium on new LTCH beds, with certain exceptions.

Relevant Legislation

- **MMSEA Section 114(d)** established a three-year moratorium (from the date of enactment, expiring after December 29, 2010) on the development of new LTCHs, with exceptions for (1) LTCHs that began their qualifying period for Medicare reimbursement before the enactment of MMSEA; (2) LTCHs that had a binding written agreement before the enactment of MMSEA for the actual construction, renovation, lease, or demolition of an LTCH, and had expended at least 10% of the estimated cost of the project (or $2.5 million, if less); and (3) LTCHs that had obtained an approved certificate of need in a state where one is required on or before the date of enactment of MMSEA. MMSEA Section 114(d) also established a three-year moratorium (expiring after December 29, 2010) on the increase in beds in existing LTCHs, with exceptions for (1) LTCHs located in a state where there is only one other LTCH and (2) LTCHs that request an increase in beds following the closure or decrease in the number of beds of another LTCH in the state.
- **ARRA Section 4302**, amended the three-year moratorium on the increase in beds in existing LTCHs by providing an exception to LTCHs that had obtained a certificate of need for such an increase in LTCH beds on or after April 1, 2005 and before the enactment of MMSEA.
- **ACA Section 3106(b)** extended the moratoria established under MMSEA an additional two years (expiring after December 29, 2012).
- **PSRA Section 1206(b)(2)** reinstated the moratoria under MMSEA beginning January 1, 2015, and expiring after September 30, 2017; however, PSRA did not allow any exceptions to the reinstated moratoria.
- **PAMA Section 112(b)** amended the moratoria reinstated by PSRA to begin with enactment of PSRA (December 26, 2013) rather than January 1, 2015. Further, this section provided the same exceptions on the development of new LTCHs that

had been provided under MMSEA but did not provide exceptions for the expansion of LTCH beds.

- **Cures Act, Division C, Section 15004** amended MMSEA Section 114(d)(7), as amended, to reinstate the exception to the moratorium on the expansion of LTCH beds effective as if it had been enacted by PAMA, April 1, 2014, to coincide with the previously reinstated exception for new LTCHs.

Current Status

The moratorium on the development of new LTCHs and the moratorium on the increase in beds in existing LTCHs will expire after September 30, 2017.

Non-application of Medicare Fee Schedule Adjustments for Wheelchair Accessories and Seat and Back Cushions When Furnished in Connection with Complex Rehabilitative Power Wheelchairs (Patient Access and Medicare Protection Act [PAMPA; P.L. 114-115] §2)

Background

Medicare covers a variety of durable medical equipment (DME) when the DME is medically necessary and prescribed by a physician. How much Medicare will pay for the equipment is determined in one of two ways. First, in *competitive bidding* geographic areas, the Medicare payments are determined for selected items based on the bids (or estimates of the cost of providing the item) submitted by winning DME suppliers. Second, outside of competitive bidding areas, payments are determined through statutorily specified formulas (*fee schedules*) adjusted based on information from the competitive bidding process, when information is available. Not all DME items are competitively bid; therefore, not all items outside of competitive bidding areas have their fee schedule payments adjusted based on competitive bidding information. Competitive bidding tends to result in lower payment amounts for DME, so adjusting the fee schedules based on competitive bidding results in lower payments.

Certain items of DME were statutorily excluded from competitive bidding competition, including Group 3 complex rehabilitative power wheelchairs and their accessories. Group 2 complex rehabilitative power wheelchairs and their accessories were not excluded and were competitively bid in the first round of competition. In general, the difference between Group 2 and Group 3 complex rehabilitative power wheelchairs has to do with the number of different power accessories that can be plugged into the chair and the power, durability, and performance of the chair. Certain accessories can be used with either Group 3 or Group 2 chairs and were part of the competitive bidding process. The HHS Secretary published final regulations on November 6, 2014, that would have adjusted the fee schedule payments for wheelchair accessories based on information from the competitive bidding program regardless of the type of wheelchair the accessory was used with, effective starting January 1, 2016, for areas outside of competitive bidding areas, resulting in lower payments for these accessories.

Relevant Legislation

- **PAMPA Section 2** prohibited the HHS Secretary from using information from the competitive bidding program to adjust the fee schedule payments for accessories furnished in conjunction with Group 3 complex rehabilitative power wheelchairs prior to January 1, 2017.

- **Cures Act, Division C, Section 16005** delayed the date when the HHS Secretary can begin using information from competitive bidding to adjust the fee schedule rates for accessories used in conjunction with Group 3 complex rehabilitative power wheelchairs by 6 months (to July 1, 2017).

Current Status

The prohibition will lapse after June 30, 2017, meaning that starting July 1, 2017, payments for accessories used with Group 3 complex rehabilitative power wheelchairs will be adjusted based on information from the competitive bidding program.

Title XIX: Medicaid

Delay in Effective Date for Medicaid Amendments Relating to Beneficiary Liability Settlements (SSA §1902(a)(25); 42 U.S.C. §1396a(a)(25))

Background

Under third-party liability (TPL) rules, Medicaid is the payer of last resort. If another insurer or payer has financial responsibility for medical services provided to Medicaid beneficiaries, generally that third party is required to pay all or part of the bill before Medicaid pays. Under federal Medicaid law applicable to TPL, states are required to determine if third parties exist and to ensure that providers bill third parties first, before billing Medicaid. DRA strengthened Medicaid TPL by clarifying what entities are considered third parties and requiring states to pass laws that stipulate third parties must comply with federal Medicaid TPL law.

States also are required under federal Medicaid TPL law to recover from judgments awarded to Medicaid beneficiaries. For example, if an individual receives medical care following an accident for which Medicaid paid, and the individual later wins a judgment against a third party responsible for that accident (e.g., another driver's auto insurance), the state must recover the amount Medicaid paid for the beneficiary's treatment from that third party. Recent court cases limited states' ability to recover from such judgments to the medical care costs, not the entire settlement or the settlement amounts attributable to lost wages or nonmedical costs.[13]

Relevant Legislation

- The **Bipartisan Budget Act of 2013 (BBA 13;** P.L. 113-67**, Division A), Section 202**, "Strengthening Medicaid Third-Party Liability," amended the SSA to enable states to recover all portions of judgments received by Medicaid beneficiaries. In addition, Section 202 clarified that states may impose liens against Medicaid beneficiaries' property. These changes were effective October 1, 2014.
- **PAMA Section 211** delayed the effective date of the beneficiary liability settlement amendment from October 1, 2014, until October 1, 2016.
- **MACRA Section 220** delayed the effective date for beneficiary liability settlements from October 1, 2016, until October 1, 2017.

[13] Arkansas Dept. of Health and Human Services v. Ahlborn and Wos v. E.M.A.

Current Status

State Medicaid programs may recover all beneficiary liability settlements beginning on October 1, 2017.

Medicaid and CHIP Express Lane Option (SSA §§1902(e)(13)(A)(i) and 1902(e)(13)(I); 42 U.S.C. §1396a(e)(13))

Background

Under this Medicaid and CHIP state plan option, states are permitted to rely on a finding from specified Express Lane agencies (e.g., agencies that administer programs such as State Temporary Assistance for Needy Families [TANF], Medicaid, CHIP, and the Supplemental Nutrition Assistance Program) for

- determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility for Medicaid or CHIP,
- eligibility redeterminations for Medicaid or CHIP, or
- renewal of eligibility coverage under Medicaid or CHIP.

Relevant Legislation

- **CHIPRA Section 203** created a state plan option for Express Lane eligibility, through September 30, 2013.
- **ATRA Section 623** permitted states to rely on Express Lane eligibility determinations through September 30, 2014.
- **PAMA Section 203** permitted states to rely on Express Lane eligibility determinations through September 30, 2015.
- **MACRA Section 302** extended authority for Express Lane eligibility determinations through September 30, 2017.

Current Status

The authority for Express Lane eligibility determinations will expire after September 30, 2017.

Title XXI: State Children's Health Insurance Program (CHIP)

CHIP Appropriations (SSA §2104(a); 42 U.S.C. §1397dd(a))

Background

Federal funding for CHIP is provided with appropriation amounts in statute that are the overall annual ceiling on federal CHIP spending to the states, the District of Columbia, and the territories. CHIP was established as part of BBA 97. Since that time, other federal laws have provided additional years of appropriation amounts.

Relevant Legislation

- **BBA 97 Section 4901** provided appropriations amounts for FY1998 through FY2007.
- **Continuing Resolutions (**P.L. 110-92**, Section 106;** P.L. 110-116**, Section 101;** P.L. 110-137**; and** P.L. 110-149**)** provided an FY2008 CHIP appropriation amount of $5.04 billion, the same amount used in FY2007, through specified termination dates (respectively, November 16, December 14, December 21, and December 31, 2007).
- **MMSEA Section 201** made the appropriation amount for FY2008 available through March 31, 2009. It also appropriated $5.04 billion for FY2009 allotments, available through March 31, 2009.
- **CHIPRA Sections 101 and 108** provided appropriations for FY2009 through FY2013.
- **ACA Section 2101, as modified by Section 10203(d)**, provided annual national appropriation amounts for an additional two years (i.e., FY2014 and FY2015).
- **MACRA Section 301(a)** extended federal CHIP funding for two years by adding federal appropriations for FY2016 and FY2017. The funding amounts are $19.30 billion for FY2016 and $20.40 billion for FY2017. The FY2017 appropriation is the combination of semiannual appropriations of $2.85 billion from SSA Section 2104(a) and a one-time appropriation in the amount of $14.70 billion.

Current Status

CHIP appropriations have not been enacted for FY2018 or subsequent fiscal years.

CHIP Child Enrollment Contingency Funds (SSA §2104(n); 42 U.S.C. §1397dd(n))

Background

If a state's CHIP allotment for the current year, in addition to any allotment funds carried over from the prior year, is insufficient to cover the projected CHIP expenditures for the current year, a few different shortfall funding sources are potentially available. These sources include Child Enrollment Contingency Fund payments, redistribution funds, and Medicaid funds. For FY2009 through FY2015, Child Enrollment Contingency Fund payments have been available to states with both a funding shortfall (i.e., current year CHIP allotment plus any unused CHIP allotment funds from the previous year are insufficient to cover the federal share of the state's CHIP program) and CHIP enrollment for children exceeding a target level. As a result, not all states with funding shortfalls are eligible for Child Enrollment Contingency Fund payments. The contingency fund payments are based on a state's growth in CHIP enrollment and per capita spending. This means that a state may receive a payment from the fund that does not equal the state's actual shortfall in CHIP funding.

Relevant Legislation

- **CHIPRA Section 103** established the Child Enrollment Contingency Fund and authorized the fund through FY2013.

- **ACA Section 2101, as modified by Section 10203(d),** extended authority for the Child Enrollment Contingency Fund through FY2015.
- **MACRA Section 301(d)** extended the funding mechanism for the Child Enrollment Contingency Fund and payments from the fund through FY2017.

Current Status

Appropriations for CHIP Child Enrollment Contingency Fund payments have not been enacted for FY2018 or subsequent fiscal years.

CHIP Qualifying State Option (SSA §2105(g)(4); 42 U.S.C. §1397ee(g)(4))

Background

In a few situations, federal CHIP funding is used to finance Medicaid expenditures. For instance, certain states significantly expanded Medicaid eligibility for children prior to the enactment of CHIP in 1997. These states are allowed to use their CHIP allotment funds to fund the difference between the Medicaid and CHIP matching rates (i.e., federal medical assistance percentage [FMAP] and enhanced federal medical assistance percentage [E-FMAP] rates, respectively) to finance the cost for children above 133% of the federal poverty level in Medicaid. The following 11 states meet the definition: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. This is referred to as the *qualifying state* option.

Relevant Legislation

- **State Children's Health Insurance Program Allotments Extension Act (P.L. 108-74), Section 1(b)**, added the authority for qualifying states to use certain funds for Medicaid expenditures.
- **DRA Section 6103** continued authority for qualifying states to use available FY2001, FY2004, and FY2005 CHIP funds for certain Medicaid expenditures.
- **National Institutes of Health Reform Act of 2006 (**P.L. 109-482**), Section 201(b)**, continued authority for qualifying states to use any available FY2006 and FY2007 CHIP funds for certain Medicaid expenditures.
- **Continuing Resolutions (**P.L. 110-92**, Section 106;** P.L. 110-116**, Section 101;** P.L. 110-137**; and** P.L. 110-149**)** permitted the use of FY2008 allotments for expenditures allowed for qualifying states under SSA Section 2105(g), through the specified termination dates.
- **MMSEA Section 201** made permanent qualifying states' ability to use their FY2008 allotments for expenditures under SSA Section 2105(g), as initially permitted under the continuing resolutions. Qualifying states' ability to use FY2009 allotments under SSA Section 2105(g) was permitted through March 31, 2009.
- **CHIPRA Section 107** allowed qualifying states to use CHIP allotments for FY2009 through FY2013 for certain Medicaid expenditures.
- **ACA Section 2101, as modified by Section 10203(d)**, extended the authorization for the qualifying state option through FY2015.
- **MACRA Section 301(c)** extended the qualifying state option through FY2017.

Current Status

The authority for the CHIP qualifying state option will expire after September 30, 2017.

CHIP Outreach and Enrollment Grants (SSA §§2113(a)(1) and 2113(g); 42 U.S.C. §1397mm)

Background

CHIPRA Section 201 appropriated (out of funds in the Treasury that were not otherwise appropriated) $100 million in outreach and enrollment grants for FY2009-FY2013 to be used by eligible entities (e.g., states, local governments, community-based organizations, elementary or secondary schools) to conduct outreach and enrollment efforts that increase the participation of Medicaid and CHIP-eligible children. Of the total appropriation, 10% is directed to a national campaign to improve the enrollment of underserved child populations and 10% is targeted to outreach for Native American children. The remaining 80% is distributed among eligible entities for the purpose of conducting outreach campaigns, focusing on rural areas and underserved populations. Grant funds also are targeted at proposals that address cultural and linguistic barriers to enrollment.

Relevant Legislation

- **ACA Section 10203(d)(2)(E)** appropriated $140 million for the period of FY2009 through FY2015 for CHIP outreach and enrollment grants.
- **MACRA Section 303** appropriated $40 million for FY2016 and FY2017 for outreach and enrollment grants.

Current Status

Appropriated funds for CHIP outreach and enrollment grants have not been enacted for FY2018 or subsequent fiscal years.

Public Health Service Act (PHSA) CY2017 Expiring Provisions

Community Health Center Fund (PHSA §330; 42 U.S.C. §254b-2(b)(1))

Background

The Community Health Center Fund (CHCF) provided mandatory funding for federal health centers authorized in the Public Health Service Act (PHSA), Section 330. These centers are located in medically underserved areas and provide primary care, dental care, and other health and supportive services to individuals regardless of their ability to pay. The mandatory CHCF appropriations are provided in addition to discretionary funding for the program; however, the CHCF comprised approximately 70% of health center programs' appropriations in FY2016.

Relevant Legislation

- **ACA Section 10503** established the CHCF and appropriated a total of $9.5 billion to the fund annually from FY2011 through FY2015, as follows: $1 billion for FY2011; $1.2 billion for FY2012; $1.5 billion for FY2013; $2.2 billion for FY2014; and $3.6 billion for FY2015. The ACA also appropriated $1.5 billion for health center construction and renovation for the period FY2011 through FY2015.
- **MACRA Section 221** appropriated $3.6 billion for each of FY2016 and FY2017 to the CHCF.

Current Status

Appropriated funds for CHCF funds have not been enacted for FY2018 or subsequent fiscal years. Any unused portion of grants awarded for a given fiscal year prior to October 1, 2017, remains available until expended.

Special Diabetes Programs (PHSA §§330B and 330C; 42 U.S.C. §§254c-2(b) and 254c-3(b))

Background

The Special Diabetes Program for Type I Diabetes (PHSA Section 330B) provides funding for the National Institutes of Health to award grants for research into the prevention and cure of Type I diabetes. The Special Diabetes Program for Indians (PHSA Section 330C) provides funding for the Indian Health Service (IHS) to award grants for services related to the prevention and treatment of diabetes for American Indians and Alaska Natives who receive services at IHS-funded facilities.

Relevant Legislation

- **BBA 97 Sections 4921 and 4922** established the two special diabetes programs and transferred $30 million annually from CHIP funds to each program from FY1998 through FY2002.
- **BIPA 2000 Section 931** increased each program's annual appropriations to $70 million for FY2001 through FY2002 and appropriated $100 million for FY2003.
- P.L. 107-360 **Section 1** increased each program's annual appropriations to $150 million and appropriated funds from FY2004 through FY2008.
- **MMSEA Section 302** extended each program's annual appropriations of $150 million through FY2009.
- **MIPPA Section 302** extended each program's annual appropriations of $150 million through FY2011.
- **MMEA Section 112** extended each program's annual appropriations of $150 million through FY2013.
- **ATRA Section 625** extended each program's annual appropriations of $150 million through FY2014.
- **PAMA Section 204** extended each program's annual appropriations of $150 million through FY2015.

- **MACRA Section 213** extended each program's annual appropriations of $150 million through FY2017.

Current Status

Appropriated funds for the two special diabetes programs have not been enacted for FY2018 or subsequent fiscal years. The funds appropriated for FY2017 will no longer be available for obligation after September 30, 2017.

National Health Service Corps Appropriations (PHSA §338H; 42 U.S.C. §254b-2(b)(2))

Background

The ACA created the CHCF, which provided mandatory funding for the National Health Service Corps (NHSC), authorized in Title III of the PHSA. The NHSC provides scholarships and loan repayments to certain health professionals in exchange for providing care in a health professional shortage area for a period of time that varies based on the length of the scholarship or the number of years of loan repayment received. This program last received discretionary appropriations in FY2011; since that time, CHCF funds have been the sole source of NHSC funding.

Relevant Legislation

- **ACA Section 10503** appropriated $1.5 billion to support the NHSC annually from FY2011 through FY2015, as follows: $290 million for FY2011, $295 million for FY2012, $300 million for FY2013, $305 million for FY2014, and $310 million for FY2015. Funds are to remain available until expended.
- **MACRA Section 221** appropriated $310 million for each of FY2016 and FY2017 for the NHSC.

Current Status

Appropriated funds for CHCF funds have not been enacted for FY2018 or subsequent fiscal years. Any unused portion of grants awarded for a given fiscal year prior to October 1, 2017, will remain available until expended.

Teaching Health Centers (PHSA §340H; 42 U.S.C. §256h)

Background

The Teaching Health Center program provides direct and indirect graduate medical education (GME) payments to support medical and dental residents training at qualified teaching health centers, outpatient health care facilities that provide care to underserved patients.

Relevant Legislation

- **ACA Section 5508(a)** established the Teaching Health Center program and appropriated $230 million for direct and indirect GME payments for the period of FY2011 through FY2015.
- **MACRA Section 221** appropriated $60 million for each of FY2016 and FY2017 for direct and indirect GME payments for teaching health centers.

Current Status

Appropriated funds for the Teaching Health Center GME payments have not been enacted for FY2018 or subsequent fiscal years. The funds appropriated for FY2017 will no longer be available for obligation after September 30, 2017. The program is currently funding existing Teaching Health Center programs with FY2016 MACRA funds; the program did not make awards to new programs in FY2016 and does not plan to make new awards in FY2017.

Other CY2017 Expiring Provisions

Annual Fee on Health Insurance Providers (ACA §9010)

Background

An annual fee is imposed on certain health insurance issuers. The aggregate fee is set at $8.0 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, and $14.3 billion in 2018. After 2018, the fee is indexed to the annual rate of U.S. premium growth. The fee is based on net health care premiums written by covered issuers during the year prior to the year in which payment is due. Each year the Internal Revenue Service apportions the fee among covered issuers based on (1) their net premiums written in the previous calendar year as a share of total net premiums written by all covered issuers and (2) their dollar value of business. Covered issuers are not subject to the fee on their first $25 million of net premiums written. The fee is imposed on 50% of net premiums above $25 million and up to $50 million and on 100% of net premiums in excess of $50 million. The fee became effective for CY2014. Collection of the fee is suspended for CY2017.

Relevant Legislation

- **ACA Section 9010** established the annual fee on certain health insurance issuers.
- The **Consolidated Appropriations Act of 2016 (CAA 16;** P.L. 114-113**), Division P, Title II, Section 201**, suspended collection of the fee for CY2017.

Current Status

The moratorium on the collection of the fee is to end after CY2017, meaning covered entities will be subject to the fee again beginning in CY2018.

Excise Tax on Medical Device Manufacturers (26 U.S.C. §4191)

Background

An excise tax is imposed on the sale of certain medical devices. The tax is equal to 2.3% of the device's sales price and generally is imposed on the manufacturer or importer of the device. The tax went into effect on January 1, 2013. Beginning January 1, 2016 the tax was suspended. It will apply to sales of medical devices again beginning January 1, 2018.

Relevant Legislation

- The **Health Care and Education Reconciliation Act of 2010 (HCERA;** P.L. 111-152**), Section 1405**, created the excise tax on medical device manufacturers.

- **CAA 16, Division Q, Title I, Subtitle C, Part 2, Section 174**, suspended imposition of the tax beginning on January 1, 2016, and ending after December 31, 2017.

Current Status

The suspension of the tax is to end December 31, 2017, meaning the tax is to apply to sales of medical devices again beginning January 1, 2018.

CY2016 Expired Provisions

SSA Title XVIII: Medicare

Funding to Fight Fraud, Waste, and Abuse (SSA §1817(k)(8); 42 U.S.C. §1395i(k))

Background

Most program integrity activities that address health care fraud, waste, and abuse are funded through the Health Care Fraud and Abuse Control (HCFAC) account, authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191). HCFAC was established to increase and stabilize federal funding for health care antifraud activities. The HCFAC account funds the following two programs: (1) the Health Care Fraud and Abuse Control Program and (2) the Medicare Integrity Program (MIP). The Health Care Fraud and Abuse Control Program finances HHS, the HHS Office of the Inspector General, the Department of Justice, and the Federal Bureau of Investigation administrative and operational (investigation, prosecution, audits, evaluation, and education) activities. The MIP finances CMS Medicare program integrity activities, which generally are conducted through contractors, and MIP administrative activities. Congress authorized annual mandatory appropriations from the Medicare HI Trust Fund to fund both the Health Care Fraud and Abuse Control Program and the MIP.

Relevant Legislation

- **HIPAA Section 201** appropriated $104 million to the HCFAC account for FY1997 and authorized annual FY1998-FY2003 appropriations based on the amount allocated in the previous year increased by 15%.
- **TRHCA Section 303** extended the annual mandatory appropriation for the HCFAC account for FY2004-FY2006 at the FY2003 appropriation limit. For FY2007-FY2010, TRHCA extended the HCFAC account appropriation at the total amount appropriated for FY2006 and authorized an inflation adjustment increase for FY2007-FY2010 to HCFAC's fraud and abuse program component by adjusting the total amount appropriated for the previous year by changes in the Consumer Price Index for All Urban Consumers (CPI-U). TRHCA did not extend the CPI-U adjustment to the MIP component. Moreover, TRHCA authorized HCFAC account appropriations to be available until expended.
- **ACA Section 6402** appropriated an additional $10 million annually on top of previously appropriated funding to the HCFAC account for FY2011-FY2020.

ACA Section 6402 also authorized a CPI-U inflation adjustment to MIP appropriations applied to the total amount appropriated for the previous year.

- **HCERA Section 1303** appropriated additional funding to the HCFAC account on top of previously appropriated funding in the following amounts for FY2011-FY2016: FY2011, $95 million; FY2012, $55 million; FY2013, $30 million; FY2014, $30 million; FY2015, $20 million; FY2016, $20 million. These appropriations were available until expended.

Current Status

The additional HCFAC appropriations ($20 million in FY2016) authorized by HCERA Section 1303 have not been enacted for FY2017 or subsequent fiscal years. However, funds appropriated prior to FY2017 are available for obligation until expended.

Temporary Exception for Certain Severe Wound Discharges from Certain Long Term Care Hospitals (SSA §1886(m)(6)(E); 42 U.S.C. §1395ww(m)(6)(E))

Background

Medicare reimburses LTCHs for inpatient hospital care under the LTCH PPS, which is typically higher than inpatient hospital care reimbursement under the IPPS. PSRA established patient criteria for reimbursement under the LTCH PPS and a site-neutral payment rate for LTCH patients who do not meet these criteria beginning in FY2016. Specifically, under the site-neutral policy, LTCHs receive reimbursement under the LTCH PPS if a Medicare beneficiary either (1) had a prior three-day intensive-care-unit stay at a hospital paid under the IPPS immediately preceding the LTCH stay or (2) is assigned to an LTCH PPS case-mix group that is based on the receipt of ventilator services for at least 96 hours and had a prior hospital stay at a hospital paid under the IPPS immediately preceding the LTCH stay. Discharges involving patients who have a principal diagnosis relating to a psychiatric diagnosis or rehabilitation do not qualify for the LTCH PPS rate.

In FY2016 and FY2017, for patients who do not meet these LTCH PPS criteria, the site-neutral policy establishes that the LTCH will receive a blended payment amount based on 50% of what the LTCH would have been reimbursed under the LTCH PPS rate without the site-neutral policy and 50% of the site-neutral payment rate. Beginning in FY2018, for discharges involving patients who do not meet these LTCH PPS criteria, the LTCH will receive the site-neutral payment rate, which is equal to either 100% of the IPPS reimbursement or 100% of the estimated cost of the case, whichever is lower.

Relevant Legislation

- **CAA 16, Division H, Title II, Section 231**, provided a temporary third criterion for reimbursement under the LTCH PPS for discharges before January 1, 2017. Specifically, the site-neutral policy would not apply to an LTCH discharge if all three of the following are satisfied: (1) the LTCH is a grandfathered hospital-within-hospital; (2) the LTCH is located in a rural area; and (3) the patient discharged has a severe wound—defined as a stage 3 or 4 wound, unstageable wound, nonhealing surgical wound, infected wound, fistula, osteomyelitis, or wound with morbid obesity.

- **Cures Act, Division C, Section 15010** temporarily reinstated, after a lapse period and with some modifications, the exception for severe wound discharges. The reinstated exception will apply only to LTCH discharges occurring during an LTCH's cost-reporting period beginning during FY2018. The reinstated exception, similar to the CAA 2016 exception, applies only to a grandfathered hospital-within-hospital. It eliminates the requirement from CAA 16 that an LTCH be located in a rural area and narrows the definition of a severe wound that was used in CAA 16. In addition, unlike the CAA 16 exception, only discharges associated with diagnosis-related groups relating to cellulitis or osteomyelitis are eligible for the reinstated exception.

Current Status

The authority for the temporary third criterion for reimbursement under the LTCH PPS expired for discharges after December 31, 2016. The reinstated exception will apply only to LTCH discharges occurring during an LTCH's cost-reporting period beginning during FY2018.

Other Medicare Provision[14]

Moratorium on Enforcement of Supervision Requirements in Critical Access Hospitals (P.L. 113-198 §1)

In the Medicare hospital outpatient prospective payment system (OPPS) 2009 final rule, CMS established that outpatient therapeutic services furnished in hospital outpatient departments are required to have direct physician supervision, defined as having a physician "present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure."[15]

On March 15, 2010, CMS instructed its Medicare contractors not to enforce these supervision requirements with respect to critical access hospitals (CAHs) in CY2010. As CMS continued to refine its direct supervision policy, the agency extended the moratorium on enforcement through CY2011 and expanded the scope of the moratorium to include both CAHs and small rural hospitals (which CMS defined as having 100 or fewer beds, being geographically located in a rural area, or being paid under the OPPS using a rural wage index). On November 1, 2012, CMS issued a notice that extended the moratorium through the end of CY2013.

Relevant Legislation

- P.L. 113-198**, Section 1** extended the moratorium through the end of CY2014.
- P.L. 114-112**, Section 1** extended the moratorium through the end of CY2015.
- **Cures Act, Division C, Section 16004** extended the moratorium through the end of CY2016.

[14] The provision in this subsection applies to Medicare but is freestanding and does not amend the SSA.

[15] CMS, "Final Rule: Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates" 74 *Federal Register* 60316-60983, November 20, 2009.

Current Status

The moratorium on enforcement of the requirement of direct supervision of outpatient therapeutic services furnished in CAHs and small rural hospitals expired after December 31, 2016.

Appendix A. Demonstration Projects and Pilot Programs

This appendix lists selected health care-related demonstration projects and pilot programs that are scheduled to expire during the 115th Congress, first session (i.e., during calendar year [CY] 2017). As in the report, expiring demonstration projects and pilot programs are similarly defined as having portions of law that are time limited and will lapse once a statutory deadline is reached, absent further legislative action. The expiring demonstration projects and pilot programs included in this appendix are those related to Medicare, Medicaid, State Children's Health Insurance Program (CHIP), and private health insurance programs and activities.[16] The report also includes other health care-related provisions that were last extended under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10). Additionally, this appendix lists health care-related demonstration projects and pilot programs within the same scope that expired during the 114th Congress, second session (i.e., during CY2016).

Although the Congressional Research Service (CRS) has attempted to be comprehensive, it cannot guarantee that every relevant demonstration project and pilot program is included here.

Table A-1, below, lists the relevant demonstration projects and pilot programs that are scheduled to expire in 2017. **Table A-2**, which follows, lists the relevant provisions that expired during 2016.

Table A-1. Demonstration Projects and Pilot Programs Expiring in the 115th Congress, First Session

(CY2017)

Expires After	Health Care-Related Program	Provision	
March 23, 2017	Other	Demonstration Program to Increase Access to Dental Health Care Services[a]	PHSA §340G-1 42 U.S.C. §256g-1
September 30, 2017	Medicare	Medicare Independence at Home Demonstration Program[b]	SSA §1866E(e)(1) 42 U.S.C. §1395cc-5
September 30, 2017	Medicare	Medicare IVIG Access Demonstration[c]	P.L. 112-242, §101 42 U.S.C. §1395l note
September 30, 2017	Other	Funding for Childhood Obesity Demonstration Project[d]	SSA §1139A(e)(8) 42 U.S.C. §1302b-9a(e)
September 30, 2017	Other	Demonstration Projects to Address Health Professions Workforce Needs[e]	SSA §2008(c) 42 U.S.C. §1397g

Source: Congressional Research Service.

[16] Section 3021 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) amended Title XI of the Social Security Act (SSA) to establish the Center for Medicare and Medicaid Innovation (CMMI). CMMI is authorized to test payment and service delivery models to improve the quality of care and/or reduce spending. For more information on the Center for Medicare and Medicaid Innovation (CMMI), see https://innovation.cms.gov/, and Centers for Medicare & Medicaid Services, CMMI, *Report to Congress: December 2016*, at https://innovation.cms.gov/Files/reports/rtc-2016.pdf.

Notes: CMS = Centers for Medicare & Medicaid Services; FY = fiscal year; IVIG = Intravenous Immune Globulin; PHSA = Public Health Service Act; SSA = Social Security Act; U.S.C. = *U.S. Code*.

a. A provision prohibiting the Health Resources and Services Administration from funding this demonstration program has been included in the Departments of Labor, Health and Human Services, Education, and Related Agencies appropriations act for each of FYs 2011-2016 and for FY2017 appropriations under continuing resolutions (P.L. 114-223 and P.L. 114-254).

b. The statute requires the demonstration program to begin no later than January 1, 2012, and authorizes provider agreements for a maximum five-year period. According to CMS, the demonstration performance period ends September 30, 2017 (CMS, *Independence at Home Demonstration Fact Sheet*, July 2016). For more information, see https://innovation.cms.gov/initiatives/independence-at-home/.

c. The statute requires the demonstration to begin no later than one year after the date of enactment (January 10, 2013) for a three-year period. According to CMS, the demonstration performance period ends September 30, 2017. For more information, see https://innovation.cms.gov/initiatives/ivig/.

d. For more information, see https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/reducing-obesity/index.html.

e. For more information, see https://www.acf.hhs.gov/ofa/programs/hpog.

Table A-2. Demonstration Projects and Pilot Programs That Expired in the 114th Congress, Second Session

(CY2016)

Expires After	Health Care-Related Program	Provision	
September 30, 2016	Medicaid	Money Follows the Person Rebalancing Demonstration[a]	DRA §607 42 U.S.C. §1396a note
December 31, 2016	Medicaid	Integrated Care Around a Hospitalization Demonstration[b]	ACA §2704 42 U.S.C. §1396a note
December 31, 2016	Medicaid	Pediatric Accountable Care Organization Demonstration Project[c]	ACA §2706 42 U.S.C. §1396a note

Source: Congressional Research Service.

Notes: ACA = P.L. 110-148, Patient Protection and Affordable Care Act; CMS = Centers for Medicare & Medicaid Services; DRA = P.L. 109-171, Deficit Reduction Act of 2005; U.S.C. = *U.S. Code*.

a. For more information see https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html.

b. According to March 15, 2016, email correspondence with CMS, this demonstration project was never implemented, as CMS focused agency resources on other similar delivery system reform initiatives (e.g., the State Innovation Model Initiative).

c. As of the date of this report's publication, no public information regarding the demonstration project's status was located.

Appendix B. Laws That Created, Modified, or Extended Current Health Care-Related Expiring Provisions

Table B-1. Laws That Created, Modified, or Extended Current Health Care-Related Expiring Provisions

P.L. #	Acronym	Act Title
P.L. 97-248	TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
P.L. 101-239	—	Omnibus Budget Reconciliation Act of 1989
P.L. 101-508	OBRA 90	Omnibus Budget Reconciliation Act of 1990
P.L. 104-191	HIPPA	Health Insurance Portability and Protection Act of 1996
P.L. 104-193	PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
P.L. 105-33	BBA 97	Balanced Budget Act of 1997
P.L. 106-113	BBRA 99	Balanced Budget Refinement Act of 1999
P.L. 106-554	BIPA 2000	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
P.L. 107-360	—	An Act to Amend the Public Health Service Act with Respect to Special Diabetes Programs for Type 1 Diabetes and Indians
P.L. 108-40	WREA 2003	Welfare Reform Extension Act of 2003
P.L. 108-74	—	State Children's Health Insurance Program Allotments Extension Act
P.L. 108-89	—	An Act to Extend the Temporary Assistance for Needy Families Block Grant Program, and Certain Tax and Trade Programs, and For Other Purposes
P.L. 108-173	MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003[a]
P.L. 108-210	WREA 2004	Welfare Reform Extension Act of 2004
P.L. 108-262	—	TANF and Related Programs Continuation Act of 2004
P.L. 108-308	—	Welfare Reform Extension Act, Part VIII
P.L. 109-4	WREA 2005	Welfare Reform Extension Act of 2005
P.L. 109-19	—	TANF Extension Act of 2005
P.L. 109-91	—	QI, TMA, and Abstinence Programs Extension and Hurricane Katrina Unemployment Relief Act of 2005
P.L. 109-171	DRA	Deficit Reduction Act of 2005
P.L. 109-432	TRHCA	Tax Relief and Health Care Act of 2006
P.L. 109-482	—	National Institutes of Health Reform Act of 2006
P.L. 110-48	—	An Act to Provide for the Extension of Transitional Medical Assistance, and Other Provisions
P.L. 110-90	—	TMA, Abstinence Education, and QI Programs Extension Act of 2007
P.L. 110-92	—	Making Continuing Appropriations for the Fiscal Year 2008, and for Other Purposes
P.L. 110-116	—	Department of Defense Appropriations Act of 2008
P.L. 110-137	—	Making Further Continuing Appropriations for the Fiscal Year 2008, and for Other Purposes.

P.L. #	Acronym	Act Title
P.L. 110-149	—	Making Further Continuing Appropriations for the Fiscal Year 2008, and for Other Purposes.
P.L. 110-173	MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007[b]
P.L. 110-275	MIPPA	Medicare Improvements for Patients and Providers Act of 2008[c]
P.L. 111-3	CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009[d]
P.L. 111-5	ARRA	American Recovery and Reinvestment Act of 2009[e]
P.L. 111-148	ACA	Patient Protection and Affordable Care Act of 2010[f]
P.L. 111-152	HCERA	Health Care and Education Reconciliation Act of 2010[g]
P.L. 111-309	MMEA	Medicare and Medicaid Extenders Act of 2010
P.L. 112-78	TPTCCA	Temporary Payroll Tax Cut Continuation Act of 2011
P.L. 112-96	MCTRJCA	Middle Class Tax Relief and Job Creation Act of 2012
P.L. 112-240	ATRA	American Taxpayer Relief Act of 2012[h]
P.L. 113-67	BBA 13/ PSRA	Continuing Appropriations Resolution of 2014, which includes Division A, the Bipartisan Budget Act of 2013, and Division B, the Pathway for SGR Reform Act of 2013
P.L. 113-93	PAMA	Protecting Access to Medicare Act of 2014
P.L. 113-198	—	An Act to Provide for the Extension of the Enforcement Instruction on Supervision Requirements for Outpatient Therapeutic Services in Critical Access and Small Rural Hospitals Through 2014
P.L. 114-10	MACRA	Medicare Access and CHIP Reauthorization Act of 2015[i]
P.L. 114-112	—	An Act to Provide for the Extension of the Enforcement Instruction on Supervision Requirements for Outpatient Therapeutic Services in Critical Access and Small Rural Hospitals Through 2015
P.L. 114-113	CAA 16	Consolidated Appropriations Act of 2016
P.L. 114-115	PAMPA	Patient Access and Medicare Protection Act
P.L. 114-255	Cures Act	The 21st Century Cures Act[j]

Source: Congressional Research Service (CRS).

a. See CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, and CRS Report RL32005, *Medicare Fee-for-Service Modifications and Medicaid Provisions of H.R. 1 as Enacted*.

b. See CRS Report RL34360, *P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007*.

c. See CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*.

d. See CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*.

e. The Health Information Technology for Economic and Clinical Health Act was incorporated into ARRA. A description of the Medicare provisions in that bill can be found in CRS Report R40161, *The Health Information Technology for Economic and Clinical Health (HITECH) Act*.

f. See CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, and CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*.

g. See CRS Report R41124, *Medicare: Changes Made by the Reconciliation Act of 2010 to the Patient Protection and Affordable Care Act (P.L. 111-148)*.

h. See CRS Report R42944, *Medicare, Medicaid, and Other Health Provisions in the American Taxpayer Relief Act of 2012*.

i. See CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*.

j. See CRS Report R44730, *Increasing Choice, Access, and Quality in Health Care for Americans Act (Division C of P.L. 114-255)*, which describes Division C provisions referenced in this report.

Appendix C. List of Abbreviations

AAA: Area Agencies on Aging

ACA: Patient Protection and Affordable Care Act (P.L. 111-148, as amended)

ACF: Administration for Children and Families

ACL: Administration for Community Living

ADRC: Aging and Disability Resource Center

ARRA: American Recovery and Reinvestment Act of 2009 (P.L. 111-5)

ATRA: American Taxpayer Relief Act of 2012 (P.L. 112-240)

BBA 13: Bipartisan Budget Act of 2013 (P.L. 113-67, Division A)

BBA 97: Balanced Budget Act of 1997 (P.L. 105-33)

BBRA 99: Balanced Budget Refinement Act of 1999 (P.L. 106-113)

BIPA 2000: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554)

CAA 16: Consolidated Appropriations Act of 2016 (P.L. 114-113)

CAH: Critical access hospital

CHCF: Community Health Center Fund

CHIP: State Children's Health Insurance Program

CHIPRA: Children's Health Insurance Program Reauthorization Act (P.L. 111-3)

CMS: Centers for Medicare & Medicaid Services

CPI-U: Consumer Price Index for All Urban Consumers

CRS: Congressional Research Service

CY: Calendar year

DME: Durable medical equipment

DRA: Deficit Reduction Act of 2005 (P.L. 109-171)

DSH: Disproportionate share hospital

E-FMAP: Enhanced federal medical assistance percentage

FMAP: Federal medical assistance percentage

FY: Fiscal year

GAO: Government Accountability Office

GME: Graduate medical education

GPCI: Geographic Practice Cost Index

HCERA: Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)

HCFAC: Health Care Fraud and Abuse Control

HH: Home health

HHS: Department of Health and Human Services

HI: Hospital Insurance

HIPAA: Health Insurance Portability and Protection Act of 1996 (P.L. 104-191)

HPOG: Health Profession Opportunity Grants

HRSA: Health Resources and Services Administration

IHS: Indian Health Service

IPPS: Medicare Inpatient Prospective Payment System

LTCH: Long-term care hospital

MACRA: Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10)

MAP: Measure Applications Partnership

MCTRJCA: Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96)

MEDH: Medicare-dependent hospital

MedPAC: Medicare Payment Advisory Commission

MIECHV: Maternal, Infant, and Early Childhood Home Visiting

MIP: Medicare Integrity Program

MIPPA: Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275)

MMA: Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)

MMEA: Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309)

MMSEA: Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173)

MPFS: Medicare physician fee schedule

MSA: Metropolitan Statistical Area

NHSC: National Health Service Corps

NQF: National Quality Forum

OBRA 90: Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508)

OPPS: Outpatient Prospective Payment System

PAMA: Protecting Access to Medicare Act of 2014 (P.L. 113-93)

PAMPA: Patient Access and Medicare Protection Act (P.L. 114-115)

PHSA: Public Health Service Act

PPS: Prospective payment system

PQMP: Pediatric Quality Measures Program

PREP: Personal Responsibility Education Program

PRWORA: Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)

PSRA: Pathway for SGR Reform Act of 2013 (P.L. 113-67, Division B)

SGR: Sustainable Growth Rate

SHIP: State Health Insurance Assistance Program

SMI: Supplementary Medical Insurance

SSA: Social Security Act

TANF: State Temporary Assistance for Needy Families

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248)

TPL: Third-party liability

TPTCCA: Temporary Payroll Tax Cut Continuation Act of 2011(P.L. 112-78)

TRHCA: Tax Relief and Health Care Act of 2006 (P.L. 109-432)

U.S.C.: *U.S. Code*

WREA 2003: Welfare Reform Extension Act of 2003 (P.L. 108-40)

WREA 2004: Welfare Reform Extension Act of 2004 (P.L. 108-210)

WREA 2005: Welfare Reform Extension Act of 2005 (P.L. 109-4)

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