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Health Care-Related Expiring Provisions of the 116th Congress, First Session

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SUMMARY

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June 21, 2019

Phoenix Voorhies, Coordinator
Analyst in Health Care Financing

Health Care-Related Expiring Provisions of the 116th Congress, First Session

This report describes selected health care-related provisions that are scheduled to expire during the first session of the116th Congress (i.e., during calendar year [CY]2019). 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 health care-related provisions that were enacted in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) or last extended under the Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-123). In addition, this report describes health care-related provisions within the same scope that expired during the 115th Congress (i.e., during CY2017 or CY2018). 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 legislative attention and are excluded.

The report provides tables listing the relevant provisions that are scheduled to expire in 2019 and that expired in 2018 or 2017. 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 2019 or that expired in 2018 or 2017.

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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). Mandatory spending is controlled by authorization acts; discretionary spending is controlled by appropriations acts.[1] The second type of provision defines the authority of government agencies or other entities to act, usually by authorizing a policy, project, or activity.[2] Such provisions also may temporarily delay the implementation of a regulation, requirement, or deadline, or establish a moratorium on a particular activity.[3] Expiring health care provisions that are predominantly associated with discretionary spending activities—such as discretionary authorizations of appropriations[4] 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 legislative attention and are excluded.

The report is organized as follows: **Table 1** lists the relevant provisions that are scheduled to expire in 2019. **Table 2** lists the relevant provisions that expired during 2018 or 2017. The provisions in each table are organized by expiration date and applicable health care-related program.

The report then describes each listed provision, including a legislative history. The summaries are grouped by provisions that are scheduled to expire in 2019 followed by those that expired in 2018

[1] For further information, see CRS Report R44582, *Overview of Funding Mechanisms in the Federal Budget Process, and Selected Examples*.

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

[3] Two private health insurance provisions included in this report do not meet the report criteria, but the provisons are expiring in 2019. 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.

[4] 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: Fiscal Year 2019* (March 14, 2019), which includes provisions set to expire on or before September 30, 2019, is available at https://www.cbo.gov/publication/55015.

or 2017.[5] **Appendix A** lists demonstration projects and pilot programs that are scheduled to expire in 2019 or that expired in 2018 or 2017 and are related to Medicare, Medicaid, CHIP, and private health insurance programs and activities or other health care-related provisions that were enacted in the ACA or last extended under the BBA 2018. **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 116th Congress, First Session
(CY2019)

Expires After	Health Care-Related Program	Provision[a]		Contact
9/30/2019	Medicaid	Protections for Recipients of Home and Community-Based Services against Spouse Impoverishment	SSA §1924 42 U.S.C. §1296r-5	Kirsten Colello
9/30/2019	Medicaid	Additional Medicaid Funding for the Territories	SSA §1108 42 U.S.C. §1308	Alison Mitchel
9/30/2019	Medicare	Outreach and Assistance for Low-Income Programs	MIPPA §119 42 U.S.C. §1395b-3 note	Kirsten Colello
9/30/2019	Medicare	Temporary Extension of LTCH Site Neutral Payment Policy Transition Period	SSA §1886(m)(6)(B)(i) 42 U.S.C. §1395ww(m)(6)(B)(i)	Marco Villagrana
9/30/2019	Medicare	Temporary Exception for Certain Spinal Cord Conditions from Application of the Medicare LTCH Site Neutral Payment for Certain LTCHs	SSA §1886(m)(6)(F) 42 U.S.C. §1395ww(m)(6)(F)	Marco Villagrana
9/30/2019	Medicare	Funding for Implementation of Section 101 of MACRA	MACRA § 101(c)(3))	Jim Hahn
9/30/2019	Medicare	Priorities and Funding for Measure Development	SSA §1848(s) 42 U.S.C. §1395w-4(s)	Amanda Sarata
9/30/2019	Medicare	Contract with a Consensus-Based Entity Regarding Performance Measurement	SSA §1890(d) 42 U.S.C. §1395aaa	Amanda Sarata
9/30/2019	Medicare	Quality Measure Selection	SSA §1890A 42 U.S.C. §1395aaa-1	Amanda Sarata
9/30/2019	Medicare	Patient-Centered Outcomes Research Trust Fund	IRC §9511 and §§4375-4377, SSA §1183); 26 U.S.C. §9511; 26 U.S.C. §§4375-4377; 42 U.S.C. §1320e-2	Amanda Sarata
9/30/2019	Other	Family-to-Family Health Information Centers	SSA §501(c) 42 U.S.C. §701(c)(1)(A)(iii)	Elayne Heisler

[5] The 2019 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., new laws).

Expires After	Health Care-Related Program	Provision[a]		Contact
9/30/2019	Other	Sexual Risk Avoidance Education Program	SSA §501 42 U.S.C. §710	Adrienne Fernandes-Alcantara
9/30/2019	Other	Personal Responsibility Education Program	SSA §513 42 U.S.C. §713(f)	Adrienne Fernandes-Alcantara
9/30/2019	Other	Pregnancy Assistance Fund	ACA §10212 42 U.S.C. §18201-18204	Adrienne Fernandes-Alcantara
9/30/2019	Other	Teaching Health Centers	PHSA §340H 42 U.S.C. §256h	Elayne Heisler
9/30/2019	Other	Community Health Centers Fund	PHSA §330 42 U.S.C. §254b-2(b)(1)	Elayne Heisler
9/30/2019	Other	Special Diabetes Programs	PHSA §330B and §330C 42 U.S.C. §254c-2(b) and §254c-3(b)	Elayne Heisler
9/30/2019	Other	National Health Service Corps Appropriations	PHSA §338H 42 U.S.C. §254b-2(b)(2)	Elayne Heisler
9/30/2019	Other	Teaching Health Centers	PHSA §340H 42 U.S.C. §256h	Elayne Heisler
12/31/2019	Medicare	Floor on Work Geographic Practice Cost Indices	SSA §1848(e)(1) 42 U.S.C. §1395w-4(e)(1)(E)	Jim Hahn
12/31/2019	Medicare	Transitional Payment Rules for Certain Radiation Therapy Services	SSA §1848 42 U.S.C. 1395w-4(b)(11)	Jim Hahn
12/31/2019	Private Health Insurance	Health Coverage Tax Credit	IRC §35 26 U.S.C. §35	Bernadette Fernandez
12/31/2019	Private Health Insurance[b]	Annual Fee on Health Insurance Providers	ACA §9010	Ryan Rosso
12/31/2019	Private Health Insurance[b]	Excise Tax on Medical Device Manufacturers	26 U.S.C. §4191	Ryan Rosso

Source: Congressional Research Service (CRS).

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148. as amended), CY = Calendar Year, IRC = Internal Revenue Code, LTCH= Long-Term Care Hospital, MACRA = Medicare Access and CHIP Reauthorization Act of 2015, MIPPA = Medicare Improvements for Patients and Providers Act, PHSA = Public Health Service Act, SSA = Social Security Act, U.S.C. = *U.S. Code*.

a. Citations in statute and the *United States Code* (U.S.C.) are provided where available.

b. These two provisions did not meet the criteria for the report, but the provisons are expiring in 2019. 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.

Table 2. Provisions That Expired in the 115th Congress

(CY2017 and CY2018)

Expired After	Health Care-Related Program	Provision[a]		Contact
9/30/2017	Medicare	Delay in Applying the 25% Patient Threshold Payment Adjustment for Long-Term Care Hospitals	MMSEA §114(c) 42 U.S.C. §1395ww note	Marco Villagrana
9/30/2017	Medicare	Long-Term Care Hospital Moratoria	MMSEA §114(d) 42 U.S.C. §1395ww note	Marco Villagrana
12/31/2017	Medicare	Extension of Enforcement Instruction on Supervision Requirements for Outpatient Therapeutic Services in Critical Access and Small Rural Hospitals	P.L. 113-198	Marco Villagrana
9/30/2018	Medicare	Temporary Exception for Certain Severe Wound Discharges from Application of the Medicare Site Neutral Payment for Certain Long Term Care Hospitals	SSA §1886(m)(6)(E) and (G) 42 U.S.C. §1395ww(m)(6)(E)and (G)	Jim Hahn
12/31/2018	Medicare	Exclusion of ASC Physicians from the Medicare Meaningful Use Payment Adjustment	SSA §1848(a)(7)(D) 42 U.S.C. §1395w–4(a)(7)(D)	Jim Hahn
12/31/2018	Medicare	Delay in Authority to Terminate Contracts for MA Plans Failing to Achieve Minimum Quality Ratings	SSA §1857 42 U.S.C. §1395w-27	Paulette Morgan

Source: Congressional Research Service.

Notes: ASC = Ambulatory Surgery Centers, CY = Calendar Year, MA = Medicare Advantage, MMSEA = Medicare, Medicaid, and SCHIP Extension Act of 2007, SSA = Social Security Act, U.S.C. = *U.S. Code*.

a. Citations in statute and the *United States Code* (U.S.C.) are provided where available.

CY2019 Expiring Provisions

Social Security Act (SSA) Title V: Sexual Risk Avoidance Education Program, Personal Responsibility Education Program, and Pregnancy Assistance Fund

Family-to-Family Health Information Centers (SSA §501(c); 42 U.S.C. §701(c)(1)(A)(iii))[6]

Background

The Family-to-Family Health Information Centers program funds family-staffed and family-run centers in the 50 states, the District of Columbia, the territories, and through a tribal organization. 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 decision-making 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 in the 50 states and the District of Columbia and provided $3 million for FY2007, $4 million for FY2008, and $5 million for FY2009.
- **ACA, Section 5507,** provided $5 million for each of FY2009 through FY2012.
- **The American Taxpayer Relief Act of 2012 (ATRA;** P.L. 112-240**), Section 624,** provided $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).
- **The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA;** P.L. 114-10**), 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.
- **BBA 2018, Section 50501,** expanded the program to require that centers be developed in all of the territories and for at least one Indian tribe. It also provided $6 million for each of FY2018 and FY2019.

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

Current Status

Appropriated funds to create or maintain Family-to-Family Health Information Centers have been enacted for FY2019, but under current law no new funding will be available for FY2020 or subsequent fiscal years.

Sexual Risk Avoidance Education Program (SSA §510; 42 U.S.C. §710)

Background

The Title V Sexual Risk Avoidance Education (SRAE) program, formerly known as the Abstinence Education Grants program, provides funding for education to adolescents aged 10 to 20 exclusively on abstaining from sexual activity outside of marriage.[7] Funding is provided primarily via formula grants. The 50 states, District of Columbia, and the territories are eligible to apply for funds. Jurisdictions request Title V SRAE funds as part of their request for Maternal and Child Health Block Grant funds authorized in SSA Section 501. Funds are allocated to jurisdictions based on their relative shares of low-income children. Funding is also available for eligible entities (not defined in statute) in jurisdictions that do not apply for funding.

Relevant Legislation

- **The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA;** P.L. 104-193**), Section 912**, established the Abstinence Education Grants program and provided $50 million for each of FY1998 through FY2002.
- **The Welfare Reform Extension Act of 2003 (WREA 2003;** P.L. 108-40**), Section 6,** provided $50 million for FY2003.
- P.L. 108-89**, Section 101**, provided funding through March 31, 2014 in the manner authorized for FY2002 (i.e., $50 million, but proportionally provided for the first two quarters of FY2004).
- **The Welfare Reform Extension Act of 2004 (WREA 2004,** P.L. 108-210**), Section 2**, provided funding through June 30, 2004 in the manner authorized for FY2002.
- P.L. 108-262**, Section 2**, provided funding through September 30, 2004 in the manner authorized for FY2002.
- P.L. 108-308**, Section 2**, provided funding through March 31, 2005 in the manner authorized for FY2004.
- **The Welfare Reform Extension Act of 2005 (WREA 2005,** P.L. 109-4**), Section 2,** provided funding through June 30, 2005 in the manner authorized for FY2004.
- P.L. 109-19**, Section 2,** provided funding through September 30, 2005 in the manner authorized for FY2004.
- P.L. 109-91**, Section 102**, provided funding through December 31, 2005 in the manner authorized for FY2005.

[7] A discretionary federal program has the same name, Sexual Risk Avoidance Education program. The programs are distinguished here by referring to the mandatory program as the *Title V* Sexual Risk Avoidance Education program. For further information about both programs, see CRS Report R45183, *Teen Pregnancy: Federal Prevention Programs*.

- **The Tax Relief and Health Care Act of 2006 (TRHCA;** P.L. 109-432**), Section 401**, provided funding through June 30, 2007 in the manner authorized for FY2006.
- P.L. 110-48**, Section 1**, provided funding through September 30, 2007 in the manner authorized for FY2006.
- P.L. 110-90**, Section 2**, provided funding through December 31, 2007 in the manner authorized for FY2007.
- **The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA;** P.L. 110-173**), Section 202**, provided funding through June 30, 2008 in the manner authorized for FY2007.
- **The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA,** P.L. 110-275**), Section 201,** provided funding through June 30, 2009 in the manner authorized for FY2007.
- **ACA, Section 2954,** provided $50 million for each of FY2010 through FY2014.
- **PAMA, Section 205**, provided $50 million for FY2015.
- **MACRA, Section 214**, provided $75 million for each of FY2016 and FY2017.
- **BBA 2018, Section 50502**, renamed the program and provided $75 million for each of FY2018 and FY2019.

Current Status

Appropriated funds for the Title V SRAE program have been enacted for FY2019, but under current law no new funding will be available for FY2020 or subsequent fiscal years.

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

Background

The Personal Responsibility Education Program (PREP) takes a broad approach to teen pregnancy prevention that targets adolescents aged 10 to 20 and pregnant and parenting youth under the age of 21.[8] Education services can address abstinence and/or contraceptives to prevent pregnancy and sexually transmitted infections. PREP includes four types of grants: (1) State PREP grants, (2) Competitive PREP grants, (3) Tribal PREP, and (4) PREP–Innovative Strategies (PREIS). A majority of PREP funding is allocated to states and territories via the State PREP grant. The 50 states, District of Columbia, and the territories are eligible for funding. Funds are allocated by formula based on the proportion of youth aged 10 to 20 in each jurisdiction relative to other jurisdictions.

Relevant Legislation

- **ACA, Section 2953**, established PREP and provided $75 million annually from FY2010 through FY2014.
- **PAMA, Section 206**, provided $75 million for FY2015.
- **MACRA, Section 215,** provided $75 million for each of FY2016 and FY2017.

[8] For further information about PREP, see CRS Report R45183, *Teen Pregnancy: Federal Prevention Programs*.

- **BBA 2018, Section 50503**, provided $75 million for each of FY2018 and FY2019.

Current Status

Appropriated funds for PREP have been enacted for FY2019, but under current law no new funding will be available for FY2020 or subsequent fiscal years.

Pregnancy Assistance Fund (ACA §10212; 42 U.S.C. §18201-18204)

The Pregnancy Assistance Fund (PAF) program seeks to improve the educational, health, and social outcomes of vulnerable individuals who are expectant or new parents and their children. PAF funding is awarded competitively to the 50 states, District of Columbia, the territories, and tribal entities that apply successfully. The grantees may use the funds for providing subgrants to community service providers and selected other entities that provide services during the prenatal and postnatal periods. Grantees may also provide, in partnership with the state attorney general's office, certain legal and other services for women who experience domestic violence, sexual assault, or stalking while they are pregnant or parenting an infant. Further, grant funds can be used to support public awareness efforts about PAF services for the expectant and parenting population.

Relevant Legislation

- **ACA, Section 10212,** established the PAF program and provided $25 million for each of FY2010 through FY2019.

Current Status

Appropriated funds for the PAF program funds have been enacted for FY2019, but under current law no new funding will be available for FY2020 or subsequent fiscal years.

SSA Title VXIII: Medicare

Temporary Extension of Long-Term Care Hospital (LTCH) Site Neutral Payment Policy Transition Period (SSA §1886(m)(6)(B)(i); 42 U.S.C. §1395ww(m)(6)(B)(i))

Background

Medicare pays LTCHs for certain inpatient hospital care under the LTCH prospective payment system (LTCH PPS), which is typically higher than payments for inpatient hospital care under the inpatient prospective payment system (IPPS). PSRA amended the law so that the LTCH PPS payment is no longer available for all LTCH discharges but instead is available only for those LTCH discharges that met specific clinical criteria. Specifically, LTCHs are paid 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. (Subsequent legislation provided for other

criteria to temporarily receive payment under the LTCH PPS. See sections "Temporary Exception for Certain Spinal Cord Conditions from Application of the Medicare LTCH Site Neutral Payment for Certain LTCHs (SSA §1886(m)(6)(F); 42 U.S.C. §1395ww(m)(6)(F))" and "Temporary Exception for Certain Severe Wound Discharges from Application of the Medicare Site Neutral Payment for Certain Long Term Care Hospitals (SSA §1886(m)(6)(E) and (G); 42 U.S.C. §1395ww(m)(6)(E) and (G))" below.)

For LTCH discharges that did not qualify for the LTCH PPS based on these clinical criteria, a "site neutral payment rate" similar to the PPS for inpatient acute care hospitals (IPPS) was to be phased-in. The site neutral rate is defined as the lower of an "IPPS-comparable" per diem amount, as defined in regulations, or the estimated cost of the services involved.

Relevant Legislation

- **PSRA, Section 1206(a),** established patient criteria for payment under the LTCH PPS and a site-neutral payment rate for LTCH patients who do not meet these criteria. During a phase-in period for discharges in cost-reporting periods beginning in FY2016 and FY2017, LTCHs received a blended payment amount based on 50% of what the LTCH would have been reimbursed under the LTCH PPS rate and 50% of the site neutral payment rate. For cost-reporting periods beginning in FY2018 and subsequent years, the LTCH was to receive the site neutral payment rate.
- **BBA 2018, Section 51005,** extended the transition period to site neutral Medicare payments for LTCH patients who do not meet the patient criteria for an additional two years, to include discharges in cost-reporting periods beginning during FY2018 and FY2019. During this period, LTCHs continue to receive the 50/50 blended payment for discharges that do not meet certain LTCH PPS criteria.

Current Status

The extended transition period to site neutral payments during which LTCHs receive a blended payment for discharges that do not meet the patient criteria expires for discharges occurring in cost-reporting periods beginning during FY2020 and subsequent years.

Temporary Exception for Certain Spinal Cord Conditions from Application of the Medicare LTCH Site Neutral Payment for Certain LTCHs (SSA §1886(m)(6)(F); 42 U.S.C. §1395ww(m)(6)(F))

Background

Medicare pays LTCHs for inpatient hospital care under the LTCH PPS, which is typically higher than payments for inpatient hospital care under the IPPS. Effective for cost-reporting periods beginning in FY2016, LTCHS are paid the LTCH PPS rate for patients that meet one of the following two criteria: (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. For LTCH discharges that did not qualify for

the LTCH PPS based on these criteria, a site neutral payment rate is being phased-in for cost-reporting periods beginning FY2016 through FY2019. Subsequent legislation provided for other criteria to temporarily receive payment under the LTCH PPS. See section "Temporary Extension of Long-Term Care Hospital (LTCH) Site Neutral Payment Policy Transition Period (SSA §1886(m)(6)(B)(i); 42 U.S.C. §1395ww(m)(6)(B)(i))" for details related to site neutral payment.

Relevant Legislation

- **Cures Act, Division C, Section 15009** established an additional temporary criterion for payment under the LTCH PPS related to certain spinal cord conditions for discharges occurring in cost-reporting periods FY2018 and FY2019. Specifically, the LTCH PPS rate would apply to an LTCH discharge if all of the following are met: (1) the LTCH was a not-for-profit on June 1, 2014; (2) at least 50% of the LTCH's CY2013 LTCH PPS-paid discharges were classified under LTCH diagnosis related groups (DRGs) associated with catastrophic spinal cord injuries, acquired brain injury, or other paralyzing neuromuscular conditions; and (3) the LTCH during FY2014 discharged patients (including Medicare beneficiaries and others) who had been admitted from at least 20 of the 50 states, as determined by the Secretary of Health and Human Services (HHS) based on a patient's state of residency.

Current Status

The authority for the temporary criterion related to certain spinal cord conditions to receive payment under the LTCH PPS expires for discharges occurring in cost reporting periods beginning during FY2020 and subsequent years.

Funding for Implementation of Section 101 of MACRA (MACRA Section 101(c)(3))

Background

Section 101 of MACRA made fundamental changes to the way Medicare payments to physicians are determined and how they are updated.[9] To implement the payment modifications in Section 101 of MACRA, the law authorized the transfer of $80 million from the Supplementary Medical Insurance (SMI) Trust Fund for each fiscal year beginning with FY2015 and ending with FY2019. The amounts transferred are to be available until expended.

Relevant Legislation

- **MACRA, Section 101,** provided for the transfer of $80 million, for each of FY2015 through FY2019, from the Medicare SMI Trust Fund.

Current Status

Appropriated funds to support the activities under this subsection have not been enacted for FY2020 or subsequent fiscal years.

[9] For more information on Section 101 of MACRA, see CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10).*

Priorities and Funding for Measure Development (SSA §1848(s); 42 U.S.C. §1395w-4(s))

Background

SSA Section 1848(s) required the HHS Secretary to develop a plan for the development of quality measures for use in the Merit-based Incentive Payment System program, which is to be updated as needed. The subsection also requires the Secretary to enter into contracts or other arrangements to develop, improve, update, or expand quality measures, in accordance with the plan. In entering into contracts, the Secretary must give priority to developing measures of outcomes, patient experience of care, and care coordination, among other things. The HHS Secretary, through the Center for Medicare & Medicaid Services (CMS), annually reports on the progress made in developing quality measures under this subsection.

Relevant Legislation

- **MACRA, Section 102,** provided for the transfer of $15 million, for each of FY2015 through FY2019, from the Medicare SMI Trust Fund.

Current Status

Appropriated funds to support the activities under this subsection have not been enacted for FY2020 or subsequent fiscal years. However, funds appropriated prior to FY2020 are available for obligation through the end of FY2022.

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 hospital insurance (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),** provides $10 million for 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 provided under MACRA for FY2015 effectively replaced the funding provided under PAMA for that year; therefore, the total funding for FY2015 was $30 million. Funds were required to remain available until expended.
- **BBA 2018, Section 50206,** transferred $7.5 million from the Medicare HI and SMI Trust Funds for each of FY2018 and FY2019 to carry out both Section 1890 and SSA Section 1890A(a)-(d). The section also added new HHS reporting requirements and modified existing NQF reporting requirements to specify use of funding, among other things. Amounts transferred for each of FY2018 and FY2019 are in addition to any unobligated balances that remained from prior years' transfers.

Current Status

Appropriated funds to support the contract with the consensus-based entity from SSA Section 1890 have not been enacted for FY2020 or subsequent fiscal years. However, funds appropriated prior to FY2020 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. As part of this process, 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, while the consensus-based entity with a contract (NQF) gathers multi-stakeholder input and annually transmits that input to the Secretary. NQF fulfills this requirement through its Measure Applications Partnership (MAP), an entity that convenes 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 provided under MACRA for FY2015 replaced the funding provided under PAMA for that year; therefore, the total funding for FY2015 was $30 million.

- **BBA 2018, Section 50206,** transferred $7.5 million for each of FY2018 and FY2019 to carry out both Section 1890 and SSA Section 1890A(a)-(d). The section also added new HHS reporting requirements and modified existing NQF reporting requirements to specify use of funding, among other things. Amounts transferred for each of FY2018 and FY2019 are in addition to any unobligated balances that remained from prior years' transfers.

Current Status

Appropriated funds to carry out the measure selection activities from SSA Section 1890A(a)-(d) have not been enacted for FY2020 or subsequent fiscal years. However, funds appropriated prior to FY2020 are available for obligation until expended.

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

Background

Payments under the Medicare physician fee schedule (MPFS) are 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 in the calculation of the payment rate under the MPFS. Several laws have established a minimum value of 1.00 (floor) for the physician work GPCI for localities where the work GPCI was less than 1.00.

Relevant Legislation

- **Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA,** P.L. 108-173**), 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 December 31, 2007.
- **MMSEA, Section 103,** extended the floor through June 30, 2008.
- **MIPPA, Section 134,** extended the floor through December 31, 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.
- **Medicare and Medicaid Extenders Act of 2010 (MMEA, P.L. 111-309), Section 103,** extended the floor through December 31, 2011.
- **Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA, P.L. 112-78), Section 303,** extended the floor through February 29, 2012.
- **Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA,** P.L. 112-96**), Section 3004,** extended the floor through December 31, 2012, and required the Medicare Payment Advisory Commission (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.
- **BBA 2018, Section 50201,** extended the floor through December 31, 2019.

Current Status

The authority for the MPFS GPCI floor will expire after December 31, 2019.

Transitional Payment Rules for Certain Radiation Therapy Services (SSA §1848(b)(11); 42 U.S.C. §1395w-4(b)(11))

Background

Currently, Medicare payments for services of physicians and certain non-physician practitioners, including radiation therapy services, are made on the basis of a fee schedule.

To set payment rates under the MPFS, relative values units (RVUs) are assigned to each of more than 7,000 service codes that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative value for a service compares the relative work and other inputs involved in performing one service with the inputs involved in providing other physicians' services. The relative values are adjusted for geographic variation in input costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

CMS, which is responsible for maintaining and updating the fee schedule, continually modifies and refines the methodology for estimating RVUs. CMS is required to review the RVUs no less than every five years; the ACA added the requirement that the HHS Secretary periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule.

In determining adjustments to RVUs used as the basis for calculating Medicare physician reimbursement under the fee schedule, the HHS Secretary has authority, under previously existing law and as augmented by the ACA, to adjust the number of RVUs for any service code to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures.

Under the potentially misvalued codes authority, certain radiation therapy codes were identified as being potentially misvalued in 2015. However, because of concerns that the existing code set did not accurately reflect the radiation therapy treatments identified, CMS created several new codes during the transition toward an episodic alternative payment model.

Relevant Legislation

- **Patient Access and Medicare Protection Act (PAMPA;** P.L. 114-115**)** required CMS to apply the same code definitions, work RVUs, and direct inputs for the practice expense RVUs in CY2017 and CY2018 as applied in 2016 for these

transition codes, effectively keeping the payments for these services unchanged, subject to the annual update factor. PAMPA exempted these radiation therapy and related imaging services from being considered as potentially misvalued services under CMS's misvalued codes initiative for CY2017 and CY2018. PAMPA also instructed the HHS Secretary to report to Congress on the development of an episodic alternative payment model under the Medicare program for radiation therapy services furnished in non-facility settings.

- **BBA 2018 Section 51009,** extended the restrictions through CY2019.

Current Status

The payment restrictions expire after December 31, 2019.

Other Medicare Provisions

Outreach and Assistance for Low-Income Programs (MIPPA §119; 42 U.S.C. §1395b-3 note)

Background

The Administration for Community Living (ACL) administers federal grant programs that fund outreach and assistance to older adults, individuals with disabilities, and their caregivers in accessing various health and social services. Funding for these programs is provided through discretionary budget authority in annual appropriations to the following entities:

- State Health Insurance Assistance Programs (SHIPs): programs that provide outreach, counseling, and information assistance to Medicare beneficiaries and their families and caregivers on Medicare and other health insurance issues.
- Area Agencies on Aging (AAA): state-designated public or private nonprofit agencies that address the needs and concerns of older adults at the regional or local levels. AAAs plan, develop, coordinate, and deliver a wide range of home and community-based services. Most AAAs are direct providers of information and referral assistance programs.
- Aging and Disability Resource Centers (ADRCs): programs in local communities that assist older adults, individuals with disabilities, and caregivers in accessing the full range of long-term services and supports options, including available public programs and private payment options.

The National Center for Benefits and Outreach Enrollment assists organizations to enroll older adults and individuals with disabilities into benefit programs that they may be eligible for, such as Medicare, Medicaid, the Supplemental Security Income (SSI) program, and the Supplemental Nutrition Assistance Program (SNAP), among others.

In addition to discretionary funding for these programs, beginning in FY2009, MIPPA provided funding for specific outreach and assistance activities to Medicare beneficiaries. This mandatory funding was extended multiple times, most recently in BBA 2018 through FY2019, and provided for outreach and assistance to low-income Medicare beneficiaries including those who may be eligible for the Low-Income Subsidy program, Medicare Savings Program (MSP), and the

Medicare Part D Prescription Drug Program. The HHS Secretary is required to transfer specified amounts for MIPPA program activities from the Medicare Trust Funds.[10]

BBA 2018 also requires ACL[11] to electronically post on its website by April 1, 2019, and biennially thereafter, the following information with respect to SHIP state grants: (1) the amount of federal funding provided to each state and the amount of federal funding provided by each state to each entity and (2) other program information, as specified by the HHS Secretary. Publicly reported information must be presented by state as well as by entity receiving funds from the state.

Relevant Legislation

- **MIPPA, Section 119,** authorized and provided 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 authority for these programs and provided 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 provided 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 provided 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 provided 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 provided 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 provided $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.

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

[11] Section 50207 of BBA 2018 refers to the "Agency for Community Living."

- **BBA 2018, Section 50207,** extended authority for these programs through September 30, 2019. For FY2018 and FY2019, BBA 2018 provides funding at the FY2017 funding level of $37.5 million annually 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 BBA 2018 for low-income outreach and assistance programs will expire after September 30, 2019. However, funds appropriated will be available for obligation until expended.

Patient-Centered Outcomes Research Trust Fund (IRC §9511 and §§4375-4377, SSA §1183); 26 U.S.C. §9511; 26 U.S.C. §§4375-4377; 42 U.S.C. §1320e-2

Background

SSA Section 1181 establishes the Patient-Centered Outcomes Research Institute (PCORI), which is responsible for coordinating and supporting comparative clinical effectiveness research. PCORI has entered into contracts with federal agencies, as well as with academic and private sector research entities for both the management of funding and conduct of research. PHSA Section 937 requires the Agency for Healthcare Research and Quality (AHRQ) to broadly disseminate research findings that are published by PCORI and other government-funded comparative effectiveness research entities.

IRC Section 9511 establishes the "Patient-Centered Outcomes Research Trust Fund" (PCORTF) to support the activities of PCORI and to fund activities under PHSA Section 937. It provides annual funding to the PCORTF over the period FY2010-FY2019 from the following three sources: (1) annual appropriations, (2) fees on health insurance and self-insured plans, and (3) transfers from the Medicare HI and SMI Trust Funds. SSA Section 1183 provides for the transfer of the required funds from the Medicare Trust Funds. Transfers to PCORTF from the Medicare HI and SMI Trust Funds are calculated based on the number of individuals entitled to benefits under Medicare Part A or enrolled in Medicare Part B. IRC Sections 4375-4377 impose the referenced fees on applicable health insurance policies and self-insured health plans and describe the method for their calculation.

For each of FY2011 through FY2019, IRC Section 9511 requires 80% of the PCORTF funds to be made available to PCORI, and the remaining 20% of funds to be transferred to the HHS Secretary for carrying out PHSA Section 937. Of the total amount transferred to HHS, 80% is to be distributed to AHRQ, with the remainder going to the Office of the Secretary (OS)/HHS.

Relevant Legislation

- **ACA, Section 6301(e),** provided the following amounts to the PCORTF: (1) $10 million for FY2010, (2) $50 million for FY2011, and (3) $150 million for each of FY2012 through FY2019. In addition, for each of FY2013 through FY2019, the section provided an amount equivalent to the net revenues from a new fee that the law imposed on health insurance policies and self-insured plans. For policy/plan years ending during FY2013, the fee equals $1 multiplied by the average number of covered lives. For policy/plan years ending during each subsequent fiscal year through FY2019, the fee equals $2 multiplied by the average number of covered lives. Finally, the section (in addition to ACA Section

6301(d)) provided for transfers to PCORTF from the Medicare Part A and Part B trust funds; these are generally calculated by multiplying the average number of individuals entitled to benefits under Medicare Part A, or enrolled in Medicare Part B, by $1 (for FY2013) or by $2 (for each of FY2014 through FY2019).

Current Status

Appropriated funds to PCORTF have not been enacted for FY2020 or subsequent fiscal years. Funds transferred to the HHS Secretary under IRC Section 9511 remain available until expended. No amounts shall be available for expenditure from the PCORTF after September 30, 2019, and any amounts in the Trust Fund after such date shall be transferred to the general fund of the Treasury.

SSA Title XIX: Medicaid

Protection for Recipients of Home and Community-Based Services Against Spouse Impoverishment (SSA §1924; 42 U.S.C. 1296r-5)

Background

When determining financial eligibility for Medicaid-covered long-term services and supports (LTSS), there are specific rules under SSA Section 1924 for the treatment of a married couple's assets when one spouse needs long-term care provided in an institution, such as a nursing home. Commonly referred to as "spousal impoverishment rules," these rules attempt to equitably allocate income and assets to each spouse when determining Medicaid financial eligibility and are intended to prevent the impoverishment of the non-Medicaid spouse. For example, spousal impoverishment rules require state Medicaid programs to exempt all of a non-Medicaid spouse's income in his or her name from being considered available to the Medicaid spouse. Joint income of the couple is divided in half between the spouses, and the Medicaid spouse can transfer income to bring the non-Medicaid spouse up to certain income thresholds. Assets of the couple, regardless whose name they are in, are combined and then split in half. The non-Medicaid spouse can retain assets up to an asset threshold determined by the state within certain statutory parameters.[12] Prior to enactment of the ACA, spousal impoverishment rules applied only in situations where the Medicaid participant was receiving LTSS in an institution. States had the option to extend these protections to certain home and community-based services (HCBS) participants under a Section 1915(c) waiver program.[13]

Beginning January 1, 2014, ACA Section 2404 temporarily substituted the definition of "institutionalized spouse" under SSA Section 1924(h)(1) to include application of these spousal impoverishment protections to all married individuals who are eligible for HCBS authorized under certain specified authorities. Thus, beginning January 1, 2014, for a five-year time period,

[12] See Centers for Medicare & Medicaid Services (CMS), *2019 SSI and Spousal Impoverishment Standards,* at https://www.medicaid.gov/medicaid/eligibility/downloads/spousal-impoverishment/ssi-and-spousal-impoverishment-standards.pdf.

[13] These HCBS recipients are eligible under the "special home and community-based services waiver eligibility group" or "217 Group" in reference to the specific regulatory citation for this group at 42 CFR §435.217. Prior to Section 2404 of the ACA, states that chose to apply spousal impoverishment protections as an option for the 217 Group also had the option to treat married HCBS recipients in the 217 Group as institutionalized for the purposes of post-eligibility treatment of income (PETI) rules.

the ACA required states to apply the spousal impoverishment rules to all married individuals who are eligible for HCBS under these specified authorities, not just those receiving institutional care.[14] This modified definition expired on December 31, 2018. The 116th Congress extended the authority for these protections and included a provision regarding state flexibility in the application of income or asset disregards for married individuals receiving certain HCBS.

Relevant Legislation

- **ACA, Section 2404,** required states to extend spousal impoverishment rules to certain beneficiaries receiving HCBS for a five-year period beginning on January 1, 2014.
- **The Medicaid Extenders Act of 2019 (**P.L. 116-3**), Section 3,** extended this provision through March 31, 2019.
- **The Medicaid Services Investment and Accountability Act of 2019 (**P.L. 116-16**), Section 2,** further extends this provision through September 30, 2019.

Current Status

The authority for the extension of spousal impoverishment protections for certain Medicaid HCBS recipients will expire after September 30, 2019.

Additional Medicaid Funding for the Territories (SSA §1108; 42 U.S.C. §1308)

Background

Medicaid financing for the territories (i.e., America Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands) is different than the financing for the 50 states and the District of Columbia. Federal Medicaid funding to the states and the District of Columbia is open-ended, but the Medicaid programs in the territories are subject to annual federal capped funding.

The federal Medicaid funding for the territories comes from a few different sources. The permanent source of federal Medicaid funding for the territories is the annual capped funding. Since July 1, 2011, Medicaid funding for the territories has been supplemented by a few additional funding sources available for a limited time provided through the ACA; the Consolidated Appropriations Act, 2017 (P.L. 115-31); and BBA 2018. Prior to the availability of these additional Medicaid funding sources, all five territories typically exhausted their federal Medicaid funding prior to the end of the fiscal year.[15]

Relevant Legislation

- **ACA, Section 2005,** as modified by Section 10201, provided $6.3 billion in additional federal Medicaid funding to the territories available between July 1, 2011, and September 30, 2019.

[14] States that cover the 217 Group must also apply the PETI rules.

[15] For more information about Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Funding for the Territories*.

- **ACA, Section 1323,** provided $1.0 billion in additional federal Medicaid funding to the territories that did not establish health insurance exchanges.[16] This funding is available January 1, 2014, through December 31, 2019.
- **The Consolidated Appropriations Act, 2017 Division M, Title II,** provided an additional $295.9 million in federal Medicaid funding to Puerto Rico available through September 30, 2019.
- **BBA 2018, Division B, Subdivision 2, Title III,** increased the federal Medicaid funding for Puerto Rico by $3.6 billion and the U.S. Virgin Islands by $106.9 million. This funding may be further increased by $1.2 billion for Puerto Rico and $35.6 million for U.S. Virgin Islands if certain conditions are met.[17] This funding is available January 1, 2018, through September 30, 2019.

Current Status

The $6.3 billion in additional Medicaid federal funding under ACA Section 2005 as modified and the additional funding provided to Puerto Rico and the U.S. Virgin Islands under the Consolidated Appropriations Act, 2017 and the BBA 2018 expire after September 30, 2019, and the $1.0 billion in ACA Section 1323 funding expires after December 31, 2019.

Public Health Service Act (PHSA) CY2019 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 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 more than 70% of health center programs' appropriations in FY2019.

Relevant Legislation

- **ACA, Section 10503,** established the CHCF and provided 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 provided $1.5 billion for health center construction and renovation for the period FY2011 through FY2015.
- **MACRA, Section 221,** provided $3.6 billion for each of FY2016 and FY2017 to the CHCF.

[16] Because none of the territories established exchanges, the territories all received additional federal Medicaid funds. Also, the provision specified that Puerto Rico receive $925 million, and the HHS Secretary distributed the remaining funding among the other four territories.

[17] The certain conditions are that the HHS Secretary needs to certify that each territory (i.e., Puerto Rico and U.S. Virgin Islands) has taken steps to (1) report reliable data to the Transformed-Medicaid Statistical Information System and (2) establish a Medicaid Fraud Control Unit.

- An Act to amend the Homeland Security Act of 2002 to require the Secretary of Homeland Security to issue Department of Homeland Security-wide guidance and develop training programs as part of the Department of Homeland Security Blue Campaign, and for other purposes (P.L. 115-96), Section 3101(a), provided $550 million for the first and second quarters of FY2018 to the CHCF.
- **BBA 2018, Section 50901,** made a number of changes to the health center program replaced language that had provided two quarters of funding and provided $3.8 billion to the CHCF in FY2018 and $4.0 billion in FY2019.

Current Status

Appropriated funds for CHCF have been enacted for FY2019, but under current law no new funding is provided for FY2020 or subsequent fiscal years. Any unused portion of grants awarded for a given fiscal year prior to October 1, 2019, 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

- **The Balanced Budget Act of 1997 (BBA 97;** P.L. 105-33**), 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.
- **The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000;** P.L. 106-554**), Section 931,** increased each program's annual appropriations to $70 million for FY2001 through FY2002 and provided $100 million for FY2003.
- P.L. 107-360**, Section 1,** increased each program's annual appropriations to $150 million and provided funds from FY2004 through FY2008.
- **MMSEA, Section 302,** provided $150 million through FY2009.
- **MIPPA, Section 303,** provided $150 million through FY2011.
- **MMEA, Section 112,** provided $150 million through FY2013.
- **ATRA, Section 625,** provided $150 million through FY2014.
- **PAMA, Section 204,** provided of $150 million through FY2015.
- **MACRA, Section 213,** provided $150 million through FY2017.
- **Disaster Tax Relief and Airport and Airway Extension Act of 2017 (**P.L. 115-63**), Section 301(b),** provided $37.5 million for first quarter of FY2018 for the

Special Diabetes Program for Indians (Note: it did not provide funding for the Special Diabetes Program for Type I Diabetes.)

- P.L. 115-96**, Section 3102,** provided $37.5 million for the second quarter for the Special Diabetes Program for Indians and provided $37.5 million for the first and second quarters of FY2018 for the Special Diabetes Program for Type I Diabetes.
- **BBA 2018, Section 50902,** replaced language that had provided funding for the first and second quarters of FY2018 to provide $150 million for each program in FY2018 and FY2019.

Current Status

Appropriated funds for the two special diabetes programs have been enacted for FY2019, but under current law no new funding is provided for FY2020 or subsequent fiscal years. Any unused portion of grants awarded for a given fiscal year prior to October 1, 2019, remains available until expended.

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

Background

The National Health Service Corps (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. The NHSC receives mandatory funding from the CHCF through PHSA Title III. The NHSC also received discretionary appropriations in FY2011. Between FY2012 and FY2017, the program did not receive discretionary appropriations. Beginning in FY2018 and continuing in FY2019, the program received discretionary appropriations, primarily to expand the number and type of substance abuse providers participating in the NHSC. The mandatory funding from the CHCF represents more nearly three-quarters of the program's funding in both FY2018 and FY2019.

Relevant Legislation

- **ACA, Section 10503,** funded $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,** funded $310 million for each of FY2016 and FY2017 for the NHSC.
- P.L. 115-96**, Section 3101(b),** funded $65 million for the first and second quarters of FY2018 for the NHSC.
- **BBA 2018, Section 50901(c),** replaced language that had provided two-quarters of funding and funded $310 million for each of FY2018 and FY2019 for the NHSC.

Current Status

Appropriated funds for CHCF funds have been enacted for FY2019, but under current law no new funding is provided for FY2020 or subsequent fiscal years. Any unused portion of grants awarded for a given fiscal year prior to October 1, 2019, remains 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 (i.e., outpatient health care facilities that provide care to underserved patients).

Relevant Legislation

- **ACA, Section 5508(a),** established the Teaching Health Center program and provided $230 million for direct and indirect GME payments for the period of FY2011 through FY2015.
- **MACRA, Section 221,** provided $60 million for each of FY2016 and FY2017 for direct and indirect GME payments for teaching health centers.
- **Disaster Tax Relief and Airport and Airway Extension Act of 2017, Section 301(a),** provided $15 million for the first quarter of FY2018 for direct and indirect GME payments for teaching health centers.
- P.L. 115-96**, Section 3101(c),** struck the first quarter of funding and provided $30 million for the first and second quarters of FY2018 for direct and indirect GME payments for teaching health centers. It also limited the amount of funding that could be used for administrative purposes.
- **BBA 2018, Section 50901(d),** made a number of changes to the Teaching Health Center program and replaced language that had provided two-quarters of funding and provided $126.5 million for each of FY2018 and FY2019 for direct and indirect GME payments for teaching health centers.

Current Status

Appropriated funds for Teaching Health Center GME payments have been enacted for FY2019. Under current law no new funding is provided for FY2020 or subsequent fiscal years.

Other CY2019 Expiring Provisions

Health Coverage Tax Credit (IRC §35; 26 U.S.C. §35)

Background

The Health Coverage Tax Credit (HCTC) subsidizes 72.5% of the cost of *qualified health insurance* for eligible taxpayers and their family members. Potential eligibility for the HCTC is limited to two groups of taxpayers. One group is composed of individuals eligible for Trade Adjustment Assistance (TAA) allowances because they experienced qualifying job losses. The other group consists of individuals whose defined-benefit pension plans were taken over by the

Pension Benefit Guaranty Corporation because of financial difficulties. HCTC-eligible individuals are allowed to receive the tax credit only if they either cannot enroll in certain other health coverage (e.g., Medicaid) or are not eligible for other specified coverage (e.g., Medicare Part A). To claim the HCTC, eligible taxpayers must have qualified health insurance (specific categories of coverage, as specified in statute). The credit is financed through a permanent appropriation under 31 U.S.C. §1324(b)(2); therefore, the financing of the HCTC is not subject to the annual appropriations process.

Relevant Legislation

- **The Trade Act of 2002 (**P.L. 107-210**), Sections 201-203,** authorized the Health Coverage Tax Credit, specified the eligibility criteria for claiming the credit, and made conforming amendment to the *U.S. Code* for purposes of financing the credit.
- **The American Recovery and Reinvestment Act of 2009** (**ARRA,** P.L. 111-5**), Part VI: TAA Health Coverage Improvement Act of 2009** expanded eligibility for and subsidy of the HCTC including retroactive amendments, and provided $80 million for FY2009 and FY2010 to implement the enacted changes to the HCTC.
- **The Trade Adjustment Assistance Extension Act of 2011 (**P.L. 112-40**), Section 241,** established a sunset date of before January 1, 2014.
- **The Trade Preferences Extension Act of 2015 (**P.L. 114-27**), Section 407,** retroactively reauthorized the HCTC and established a new sunset date of before January 1, 2020.

Current Status

Authorization for the HCTC is scheduled to expire after December 31, 2019.

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 CY2014, $11.3 billion in CY2015 and CY2016, $13.9 billion in CY2017, and $14.3 billion in CY2018. After CY2018, 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 calculates the fee on 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.

Relevant Legislation

- **ACA, Section 9010,** established the annual fee on certain health insurance issuers. The fee became effective for CY2014.
- **The Consolidated Appropriations Act, 2016** (P.L. 114-113**), Division P, Title II, Section 201,** suspended collection of the fee for CY2017.

- Making further continuing appropriations for the fiscal year ending September 30, 2018, and for other purposes (P.L. 115-120), Section 4003, suspended collection of the fee for CY2019.

Current Status

The moratorium on the collection of the fee is to end after CY2019, meaning covered entities are scheduled to be subject to the fee again beginning in CY2020.

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

Background

An excise tax is imposed on the sale of certain medical devices. For the purposes of the tax, a "medical device" is defined by the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §321(h)) and pertains to devices "intended for humans." Congress exempted eyeglasses, contact lenses, and hearing aids from the tax and any other medical device determined by the Secretary of the Treasury to be of the type that is "generally purchased by the general public at retail for individual use." 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.

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 starting in CY2013.
- **The Consolidated Appropriations Act, 2016, Division Q, Title I, Subtitle C, Part 2, Section 174,** suspended imposition of the tax for CY2016 and CY2017.
- Making further continuing appropriations for the fiscal year ending September 30, 2018, and for other purposes (P.L. 115-120), Section 4001, extended the suspension of the imposition of the tax for CY2018 and CY2019.

Current Status

The suspension of the tax is to end after CY2019, meaning the tax is to apply to sales of medical devices again beginning in CY2020.

CY2017 and CY2018 Expired Provisions

SSA Title XVIII: Medicare

Temporary Exception for Certain Severe Wound Discharges from Application of the Medicare Site Neutral Payment for Certain Long Term Care Hospitals (SSA §1886(m)(6)(E) and (G); 42 U.S.C. §1395ww(m)(6)(E) and (G))

Background

Medicare pays LTCHs for inpatient hospital care under the LTCH PPS, which is typically higher than payments for inpatient hospital care under the IPPS. Effective for cost-reporting periods

beginning in FY2016, LTCHS are paid the LTCH PPS rate for patients that meet one of the following two criteria: (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. For LTCH discharges that did not qualify for the LTCH PPS based on these criteria, a site neutral payment rate is being phased-in for cost-reporting periods beginning FY2016 through FY2019. Subsequent legislation provided for other criteria to temporarily receive payment under the LTCH PPS. See section "Temporary Extension of Long-Term Care Hospital (LTCH) Site Neutral Payment Policy Transition Period (SSA §1886(m)(6)(B)(i); 42 U.S.C. §1395ww(m)(6)(B)(i))" for details related to site neutral payment.

Relevant Legislation

- **The Consolidated Appropriations Act, 2016, Division H, Title II, Section 231,** provided an additional temporary criterion for payment under the LTCH PPS for discharges before January 1, 2017. Specifically, the LTCH PPS rate would 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,** reinstated, after a lapse period and with some modifications, the temporary criterion for payment under the LTCH PPS related to certain spinal cord conditions for discharges occurring in cost-reporting period beginning during FY2018. The reinstated temporary criterion, similar to the Consolidated Appropriations Act of 2016 criterion, applies only to a grandfathered hospital-within-hospital. It eliminates the requirement from Consolidated Appropriations Act of 2016 that an LTCH be located in a rural area and narrows the definition of a severe wound that was used in Consolidated Appropriations Act of 2016. In addition, unlike the Consolidated Appropriations Act of 2016 criterion, only discharges associated with diagnosis-related groups relating to cellulitis or osteomyelitis are eligible for the reinstated temporary criterion.

Current Status

The temporary criterion for certain severe wound discharges for payment under the LTCH PPS expired for discharges in cost-reporting periods beginning during FY2019 and subsequent years.

Exclusion of ASC Physicians from the Medicare Meaningful Use Payment Adjustment (SSA §1848(a)(7)(D); 42 U.S.C. §1395w–4(a)(7)(D))

Background

Congress has passed several bills to promote the widespread adoption of health information technology (HIT) and to support the electronic sharing of clinical data among hospitals, physicians, and other health care stakeholders. HIT encompasses interoperable electronic health

records (EHRs)—including computerized systems to order tests and medications, and support systems to aid clinical decision making—and the development of a national health information network to permit the secure exchange of electronic health information among providers.

Relevant Legislation

- **ARRA, Section 4101,** which incorporated the Health Information Technology for Economic and Clinical Health Act (HITECH), authorized Medicare and Medicaid incentive payments to acute-care hospitals and physicians who attest to being meaningful users of certified EHR technology. The law instructed the HHS Secretary to make the measures of "meaningful use" more stringent over time, which CMS has done in stages. Beginning in CY2015, hospitals and physicians that were or are not meaningful EHR users are subject to a Medicare payment adjustment (i.e., penalty) unless they qualify for a hardship exception.
- **Cures Act, Section 16003,** exempted physicians who furnish "substantially all" of their services to patients in ambulatory surgery centers from a meaningful use payment penalty in CY2017 and CY2018 because physicians who provide services to beneficiaries in ASCs faced additional difficulties in meeting some of the meaningful use criteria.

Current Status

The exemption as specified in the Cures Act expired December 31, 2018. Current law states that this exemption is to sunset "as of the first year that begins more than 3 years after the date on which the Secretary determines, through notice and comment rulemaking, that certified EHR technology applicable to the ambulatory surgical center setting is available." This has yet to occur.

Delay in Authority to Terminate Contracts for Medicare Advantage (MA) Plans Failing to Achieve Minimum Quality Ratings (SSA §1857; 42 U.S.C. §1395w-27)

Background

Under Medicare Advantage (Medicare Part C, or MA) CMS pays private health plans a per-enrollee amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. SSA Section 1853(o)(4) requires the HHS Secretary to use a five-star quality rating system to adjust maximum possible payments to high-performing MA plans. High star quality also results in an increase in an MA organization's rebate if its contract bid is less than the maximum amount that Medicare will pay. In addition, the five-star quality ratings are publicly reported and can be used by beneficiaries when considering which MA, Part D, or Medicare Advantage-Prescription Drug (MA-PD) plan to enroll in.

The Social Security Act authorizes the HHS Secretary to terminate a contract with an MA organization or a Perscription Drug Plan (PDP) if the HHS Secretary determines that the MA organization or PDP has failed substantially to carry out the contract, is carrying out the contract in a manner inconsistent with the efficient and effective administration of the Medicare program, or no longer meets the applicable Medicare program conditions.[18] CMS amended its regulations

[18] SSA §1857(c)(2) (contract termination authority under Medicare Advantage) and §1860D-12(b)(3)(B) (contract termination authority under Medicare Part D).

in 2012 to include a ground for contract termination relating to an MA organization's or a PDP's rating under the five-star system. Specifically, under the regulation, CMS may terminate a contract with an MA organization or a PDP if the plan receives a "summary plan rating of less than 3 stars for 3 consecutive contract years."[19] The regulation applies to plan ratings issued by CMS after September 1, 2012. CMS has terminated some MA organizations' contracts on this basis.

Relevant Legislation

- **Cures Act, Division C, Section 17001:** through the end of plan year 2018, the HHS Secretary is prohibited from terminating an MA organization's contract (or Part D contract) solely because the contract failed to achieve a minimum quality rating under the five-star rating system.

Current Status

The HHS Secretary has the authority to terminate an organization's MA or Part D contract based solely on the organization's receipt of a Part C or Part D summary rating of less than three stars for three consecutive contract years. The Secretary issued a memorandum to MA plans indicating that the first star rating released after December 2018 is the first that could count toward termination. Star ratings are released in the fall of one year, displayed for beneficiary use the next year, and then used for payment purposes the following year. As such, the CY2020 rates (released fall CY2019 and used for payment purposes in CY2021) are the first that could apply toward potential termination. The soonest possible effective date for a CMS termination of an MA contract under this policy would be December 31, 2022.

Other Medicare Provisions

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

Background

LTCHs generally treat patients who have been discharged from acute-care hospitals but require prolonged inpatient hospital care due to their medical conditions. LTCH patients have an average length of inpatient stay longer than 25 days. LTCHs can be (1) freestanding—a hospital generally not integrated with any other hospital; (2) co-located 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 separately located facility (which may be co-located with another hospital) that operates as part of the LTCH.

Beginning in FY2005, CMS implemented a new Medicare payment regulation for LTCHs that are co-located with other hospitals and LTCH satellite facilities to limit inappropriate patient shifting driven by financial rather than clinical considerations. Under the new policy, if such an LTCH received more than 25% of its Medicare patients from any single referring hospital, the LTCH is paid the lower of the LTCH PPS or the IPPS payment for discharges that exceeded the threshold.

[19] 42 C.F. R. §§422.510(a)(4)(xi), 423.509(a)(4)(x) CMS, "Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013 and Other Changes" *77 Federal Register* 22072-22175, April 12, 2012.

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 co-located with another hospital if (1) LTCHs or satellite facilities located in a rural area or co-located with an urban single or Metropolitan Statistical Area (MSA) dominant hospital receive no more than 75% of their Medicare inpatients from such co-located hospitals or (2) other LTCHs or satellite facilities co-located with another hospital receive no more than 50% of their Medicare inpatients from such co-located hospitals.
- **ARRA, 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 co-located 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 co-located 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 co-located with another hospital).
- **Cures Act, 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 co-located with another hospital).

Current Status

The statutory delay in CMS applying the 25% patient threshold adjustment to LTCHs expired after September 30, 2017. However, the HHS Secretary extended the delay through FY2018 and eliminated it beginning FY2019 through rulemaking.[20]

[20] CMS, "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2019 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims", 83 *Federal Register* 41144, August 17, 2018, see pages 41532-41533.

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 paid 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 Balanced Budget Refinement Act of 1999 (BBRA 99; P.L. 106-113), the LTCH PPS was established, which provides a per-discharge payment based on the average costs and patient mix of LTCHs. The LTCH PPS typically provides higher Medicare payment rates for inpatient hospital care than the IPPS.

The rapid increase in both the number of LTCHs and LTCH payments led to enactment of a temporary 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 (December 29, 2007) 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 from the date of enactment (December 29, 2007) 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 increase in LTCH beds.
- **Cures Act, Division C, Section 15004,** reinstated the exception to the moratorium on the increase in 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 on the increase of beds in existing LTCHs expired as of September 30, 2017.

Extension of Enforcement Instruction on Supervision Requirements for Outpatient Therapeutic Services in Critical Access and Small Rural Hospitals

Background

The 2009 Outpatient Prospective Payment System (OPPS) final rule required that therapeutic hospital outpatient services be furnished under the direct supervision of a physician.[21] However, beginning in CY2010, CMS instructed its contractors not to evaluate or enforce the supervision requirements for therapeutic services provided to outpatients in critical access hospitals (CAHs). CMS extended this non-enforcement instruction for CY2011 and expanded it to include small rural hospitals with 100 or fewer beds. Subsequently, CMS extended the instruction for CY2012 and CY2013, The non-enforcement instruction has been extended several more times through legislation and rules.

Relevant Legislation

- 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. 113-198), required the HHS Secretary to extend the non-enforcement instruction through CY2014.
- 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. 114-112**)**, required the HHS Secretary to extend the non-enforcement instruction through CY2015.
- **Cures Act, Section 16004**, extended the non-enforcement instruction through CY2016.
- **BBA 2018, Section 51007,** extended the non-enforcement instruction through CY2017 retroactively.

Current Status

Although the non-enforcement instruction has statutorily expired, the CY2018 OPPS/ Ambulatory Surgery Center (ASC) final rule with comment period re-established the non-enforcement policy beginning on January 1, 2018, and extended the instruction through December 31, 2019.[22]

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[21] CMS, "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* 60315-60983, November 20, 2009.

[22] CMS, "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs," 82 *Federal Register* 52356, November 11, 2017.

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 first session of the 116th Congress (i.e., during calendar year [CY] 2019). The expiring demonstration projects and pilot programs listed below have 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 here are those related to Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), and private health insurance programs and activities.[23] This appendix also includes other health care-related demonstration projects and pilot programs that were enacted in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) or last extended under the Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-123). In addition, this appendix lists health care-related demonstration projects and pilot programs within the same scope that expired during the 115th Congress (i.e., during CY2017 or CY2018).

Although CRS has attempted to be comprehensive, it cannot guarantee that every relevant demonstration project and pilot program is included here.

Table A-1, lists the relevant demonstration projects and pilot programs that are scheduled to expire in 2019. **Table A-2** lists the relevant provisions that expired during 2018 or 2017.

Table A-1. Demonstration Projects and Pilot Programs Expiring in the 116th Congress, First Session

(CY2019)

Expires After	Health Care-Related Program	Provision		Contact
6/30/2019[a]	Medicaid/ Other	Demonstration to Improve Community Behavioral Health Clinics	PAMA §223(f) 42 U.S.C. §1396a	Alison Mitchell
9/30/2019	Medicaid	Money Follows the Person Rebalancing Demonstration[b]	DRA §6071 42 U.S.C. §1396a note	Kirsten Colello
9/30/2019	Other	Demonstration Projects to Address Health Professions Workforce Needs[c]	SSA §2008(c) 42 U.S.C. §1397g[d]	Elayne Heisler

Source: Congressional Research Service.

Notes: CY = Calendar Year, DRA = Deficit Reduction Act of 2005, PAMA = Protecting Access to Medicare Act of 2014, SSA = Social Security Act, U.S.C. = *U.S. Code*.

a. The expiration date of Demonstration to Improve Community Behavioral Health Clinics was amended in the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), and the expiration date is effectively June 30, 2019. For more information, see https://www.samhsa.gov/section-223.

[23] 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 CMS, CMMI, *Report to Congress: December 2016*, at https://innovation.cms.gov/Files/reports/rtc-2016.pdf.

b. Extended most recently in Section 2 of the Medicaid Extenders Act of 2019 (P.L. 116-3; additional funding provided under Section 5 of the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16). For more information, see https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html.

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

d. Authorization for this program is included in SSA §2008(a), and mandatory appropriations for the program are included in SSA §2008(c).

Table A-2. Demonstration Projects and Pilot Programs That Expired in the 115th Congress,

(CY2017 and CY2018)

Expired After	Health Care-Related Program	Provision		Contact
3/23/2017	Other	Demonstration Program to Increase Access to Dental Health Care Services[a]	PHSA §340G-1 42 U.S.C. §256g-1	Elayne Heisler

Source: Congressional Research Service.

Notes: CY = Calendar Year, PHSA = Public Health Service 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 FY2011-FY2016 and for FY2017 appropriations under continuing resolutions (P.L. 114-223 and P.L. 114-254).

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. Number	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. Number	Acronym	Act Title
P.L. 110-137	—	Making Further Continuing Appropriations for the Fiscal Year 2008, and for Other Purposes.
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	—	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
P.L. 115-31	—	Consolidated Appropriations Act, 2017
P.L. 115-63	—	Disaster Tax Relief and Airport and Airway Extension Act of 2017
P.L. 115-96	—	An Act to amend the Homeland Security Act of 2002 to require the Secretary of Homeland Security to issue Department of Homeland Security-wide guidance and develop training programs as part of the Department of Homeland Security Blue Campaign, and for other purposes
P.L. 115-120	—	Making Further Continuing Appropriations for the Fiscal Year Ending September 30, 2018, and for Other Purposes.
P.L. 115-123	BBA 2018	Bipartisan Budget Act of 2018
P.L. 116-3	—	Medicaid Extenders Act of 2019
P.L. 116-16	—	Medicaid Services Investment and Accountability Act of 2019

Source: Congressional Research Service (CRS).

Notes:

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)*.

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

AHRQ: Agency for Healthcare Research and Quality

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

ASC: Ambulatory Surgery Center

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)

BBA 2018: Bipartisan Budget Act of 2018

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)

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

EHR: Electronic health record

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)

HIT: Health information technology

HITECH: Health Information Technology for Economic and Clinical Health Act

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

LTCH PPS: Long-term care hospital prospective payment system

LTSS: Long-term services and supports

MA: Medicare Advantage

MA-PD: Medicare Advantage-Prescription Drug

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)

PCORI: Patient-Centered Outcomes Research Institute

PCORTF: Patient-Centered Outcomes Research Trust Fund

PDP: Prescription Drug Plan

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)

RVU: Relative value unit

SGR: Sustainable Growth Rate

SHIP: State Health Insurance Assistance Program

SMI: Supplementary Medical Insurance

SNAP: Supplemental Nutrition Assistance Program

SSA: Social Security Act

SRAE: Sexual Risk Avoidance Education

SSI: Supplemental Security Income

TAA: Trade Adjustment Assistance

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)

Author Information

Phoenix Voorhies, Coordinator
Analyst in Health Care Financing

Kirsten J. Colello
Specialist in Health and Aging Policy

Adrienne L. Fernandes-Alcantara
Specialist in Social Policy

Bernadette Fernandez
Specialist in Health Care Financing

Jim Hahn
Specialist in Health Care Financing

Elayne J. Heisler
Specialist in Health Services

Alison Mitchell
Specialist in Health Care Financing

Paulette C. Morgan
Specialist in Health Care Financing

Ryan J. Rosso
Analyst in Health Care Financing

Amanda K. Sarata
Specialist in Health Policy

Marco A. Villagrana
Analyst in Health Care Financing

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Jessica Tollestrup, CRS Specialist in Social Policy, provided valuable input in reviewing the report.

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