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

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SUMMARY

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April 28, 2020

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

This report describes selected health care-related provisions that are scheduled to expire during the second session of the 116th Congress (i.e., during calendar year [CY] 2020). 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, the State Children's Health Insurance Program (CHIP), and private health insurance programs and activities. The report also includes health care-related provisions enacted in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) or extended under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136). In addition, this report describes health care-related provisions within the same scope that expired during the first session of the 116th Congress (i.e., during CY2019). Although the Congressional Research Service (CRS) has attempted to be comprehensive, it cannot guarantee that every relevant provision is included here.

This report focuses on two types of health care-related provisions within the scope discussed above. The first, and most common, type of provision provides or controls mandatory spending, meaning 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 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 2020 and that expired in 2019. 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 2020 or that expired in 2019.

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Overview

This report describes selected health care-related provisions that are scheduled to expire during the second session of the 116th Congress (i.e., during calendar year [CY] 2020). 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, the State Children's Health Insurance Program (CHIP), and private health insurance programs and activities. The report also includes health care-related provisions enacted in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) or extended under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136). This report describes health care-related provisions within the same scope that expired during the first session of the 116th Congress (i.e., during CY2019). Although the Congressional Research Service (CRS) has attempted to be comprehensive, it cannot guarantee that every relevant provision is included here.

The two types of provisions discussed in this report generally are enacted in the context of *authorization laws* and thus are typically within the purview of congressional authorizing committees. The duration that a provision is in effect usually is regarded as creating a timeline for legislative decisionmaking. In choosing this timeline, Congress navigates tradeoffs between the frequency of congressional review and the stability of funding or other legal requirements that pertain to the program.

- The first type of provision in this report provides or controls mandatory spending, meaning 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).[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.

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.[3]

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

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

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

[3] 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 2020* (February 5, 2020), which includes provisions set to expire on or before September 30, 2020, is available at https://www.cbo.gov/publication/56082.

rate reductions and payment rate re-basings that are implemented over a specified 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 2020. **Table 2** lists the relevant provisions that expired during 2019. 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 scheduled to expire in 2020 followed by those that expired in 2019.[4] **Appendix A** lists demonstration projects and pilot programs that are scheduled to expire in 2020 or that expired in 2019 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 Further Consolidated Appropriations Act, 2020 (P.L. 116-94). **Appendix B** lists the status of provisions included in CRS Report R45781, *Health Care-Related Expiring Provisions of the 116th Congress, First Session*, that did not apply within the scope of this report. **Appendix C** lists all laws that created, modified, or extended the health care-related expiring provisions described in this report. **Appendix D** lists abbreviations used in the report.

Table 1. Provisions Expiring in the 116th Congress, Second Session
(CY2020)

Expires After	Health Care-Related Program	Provision[a]		Contact
9/30/2020	CHIP	Increase to E-FMAP	SSA §32105(b) 42 U.S.C. §1397ee(b)	Alison Mitchell
9/30/2020	Medicare	MACRA Technical Assistance to Small Practices and Practices In Health Professional Shortage Areas	SSA §1848(q) 42 U.S.C. §1395w–4(q)	Jim Hahn
11/30/2020	Medicaid	Protections for Recipients of Home and Community-Based Services against Spouse Impoverishment	SSA §1924 42 U.S.C. 1396r-5 note	Kirsten Colello
11/30/2020	Medicare	Outreach and Assistance for Low-Income Programs	MIPPA §119 42 U.S.C. §1395b-3 note	Kirsten Colello
11/30/2020	Medicare	Quality Measure Selection	SSA §1890A 42 U.S.C. §1395aaa-1	Amanda Sarata
11/30/2020	Medicare	Contract with a Consensus-Based Entity Regarding Performance Measurement	SSA §1890(d) 42 U.S.C. §1395aaa	Amanda Sarata
11/30/2020	Medicare	Floor on Work Geographic Practice Cost Indices	SSA §1848(e)(1) 42 U.S.C. §1395w-4(e)(1)(E)	Jim Hahn
11/30/2020	Other	Sexual Risk Avoidance Education Program	SSA §501 42 U.S.C. §710	Adrienne Fernandes-Alcantara

[4] Within each section, the 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 found elsewhere (e.g. the Internal Revenue Code (IRC). Freestanding provisions (i.e., new laws) may be grouped in any section with related programs.

Expires After	Health Care-Related Program	Provision[a]		Contact
11/30/2020	Other	Personal Responsibility Education Program	SSA §513 42 U.S.C. §713(f)	Adrienne Fernandes-Alcantara
11/30/2020	Other	Community Health Centers Fund	PHSA §330 42 U.S.C. §254b-2(b)(1)	Elayne Heisler
11/30/2020	Other	Special Diabetes Programs for Indians	PHSA §330C 42 U.S.C. §254c-3(b)	Elayne Heisler
11/30/2020	Other	Special Diabetes Programs for Type I Diabetes	PHSA §330B 42 U.S.C. §254c-2(b)	Elayne Heisler
11/30/2020	Other	National Health Service Corps Appropriations	PHSA §338H 42 U.S.C. §254b-2(b)(2)	Elayne Heisler
11/30/2020	Other	Teaching Health Centers	PHSA §340H 42 U.S.C. §256h	Elayne Heisler
12/31/2020	Medicare	Home Health Prospective Payment System Rural Add-On for High Utilization Counties	SSA §1895 42 U.S.C. §1395fff note	Phoenix Voorhies
12/31/2020	Private Health Insurance	Health Coverage Tax Credit	IRC §35 26 U.S.C. §35	Bernadette Fernandez

Source: Congressional Research Service (CRS).

Notes: CHIP = State Children's Health Insurance Program, CY = Calendar Year, E-FMAP = Enhanced Federal Medical Assistance Percentage, IRC = Internal Revenue Code, 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.

Table 2. Provisions That Expired in the First Session of the 116th Congress

(CY2019)

Expired After	Health Care-Related Program	Provision[a]		Contact
9/30/2019	Other	Pregnancy Assistance Fund	ACA §10212	Adrienne Fernandes-Alcantara
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	Extension of Blended Site Neutral Payment Rate For Certain LTCH Discharges	SSA §1886(m)(6)(B)(i) 42 U.S.C. §1395ww(m)(6)(B)(i)	Marco Villagrana

Expired After	Health Care-Related Program	Provision[a]		Contact
9/30/2019	Medicare	Temporary Exception for the Application of the Medicare LTCH Site Neutral Provisions for Certain Spinal Cord Hospitals	SSA §1886(m)(6)(F) 42 U.S.C. §1395ww(m)(6)(F)	Marco Villagrana
12/31/2019	Medicare	Transitional Payment Rules for Certain Radiation Therapy Services	SSA §1848 42 U.S.C. 1395w-4(b)(11)	Jim Hahn

Source: Congressional Research Service.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended), CY = Calendar Year, LTCH = Long-Term Care Hospital, MACRA = Medicare Access and CHIP Reauthorization Act of 2015, 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.

CY2020 Expiring Provisions

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

Sexual Risk Avoidance Education Program (SSA §510; 42 U.S.C. §710)[5]

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.[6] The Department of Health and Human Services (HHS) administers the program, and 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.

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

[6] 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. In addition, HHS refers to the discretionary program as General Departmental Management Sexual Risk Avoidance Education, named for the account from which funds are appropriated for the program. For further information about both programs, see CRS Report R45183, *Teen Pregnancy: Federal Prevention Programs*.

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.
- **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. 108-89), 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.
- **TANF and Related Programs Continuation Act of 2004 (P.L. 108-262), Section 2,** provided funding through September 30, 2004 in the manner authorized for FY2002.
- **Welfare Reform Extension Act, Part VIII (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.
- **TANF Extension Act of 2005 (P.L. 109-19), Section 2,** provided funding through September 30, 2005 in the manner authorized for FY2004.
- **QI, TMA, and Abstinence Programs Extension and Hurricane Katrina Unemployment Relief Act of 2005 (P.L. 109-91), Section 102,** provided funding through December 31, 2005 in the manner authorized for FY2005.
- **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.
- **An Act to Provide for the Extension of Transitional Medical Assistance, and Other Provisions (P.L. 110-48), Section 1,** provided funding through September 30, 2007 in the manner authorized for FY2006.
- **TMA, Abstinence Education, and QI Programs Extension Act of 2007 (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.

- **Protecting Access to Medicare Act of 2014 (PAMA;** P.L. 113-93**), Section 205**, provided $50 million for FY2015.
- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA;** P.L. 114-10**), 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.
- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59), Section 1201,** provided $10,684,931 for the period of October 1, 2019 through November 21, 2019.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69), Section 1201,** provided $16,643,836 for the period of October 1, 2019 through December 20, 2019.
- **Further Consolidated Appropriations Act, 2020 (P.L. 116-94) Division N, Section 303,** provided $48,287,671 for the period of October 1, 2019 through May 22, 2020.
- **Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136), Section 3821** provided $75 million for FY2020, which supersedes the funding previously provided by law for all periods of FY2020. Additionally, funding was provided for a specified portion of FY2021 (October 1, 2020 through November 30, 2020) at the same proportional share of amounts provided during that same period in FY2020.

Current Status

Funding authorized under the CARES Act for the Title V SRAE program expires after November 30, 2020.

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

Background

The Personal Responsibility Education Program (PREP) is a broad approach to teen pregnancy prevention that seeks to educate adolescents ages 10 through 19 and pregnant and parenting youth under age 21 on both abstinence and contraceptives to prevent pregnancy and sexually transmitted infections (STIs).[7] Education services can address abstinence and/or contraceptives to prevent pregnancy and STIs. PREP includes four types of grants, which are administered by HHS: (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.

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

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.
- **BBA 2018, Section 50503,** provided $75 million for each of FY2018 and FY2019.
- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Section 1202,** provided $10,684,931 for the period of October 1, 2019 through November 21, 2019.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Section 1202,** provided $16,643,836 for the period of October 1, 2019 through December 20, 2019.
- **Further Consolidated Appropriations Act, 2020, Division N, Section 304,** provided $48,287,671 for the period of October 1, 2019 through May 22, 2020.
- **CARES Act, Section 3822** provided $75 million for FY2020, which supersedes the funding previously provided by law for all periods of FY2020. Additionally, funding was provided for a specified portion of FY2021 (October 1, 2020 through November 30, 2020) at the same proportional share of amounts provided during that same period in FY2020.

Current Status

Funding authorized under the CARES Act for PREP expires after November 30, 2020.

SSA Title VXIII: Medicare

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 (National Quality Form, or 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 Hospital Insurance (HI) and Supplementary Medical Insurance (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)).[8]

- **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.
- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Section 1401,** transferred $1,069,000 for the period beginning October 1, 2019, and ending November 21, 2019.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Section 1401,** transferred $1,665,000 for the period beginning October 1, 2019, and ending December 20, 2019.
- **Further Consolidated Appropriations Act, 2020, Division N, Section 102,** transferred $4,830,000 for the period beginning October 1, 2019, and ending May 22, 2020.
- **CARES Act, Section 3802,** provided $20 million for FY2020, which supersedes the funding previously provided by law for all periods of FY2020. Additionally, funding was provided for a specified portion of FY2021 (October 1, 2020 through November 30, 2020) at the same proportional share of amounts provided during that same period in FY2020.

Current Status

Funding authorized under the CARES Act to carry out the measure selection activities under SSA Section 1890A(a)-(d) expires after November 30, 2020.

[8] 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.

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., NQF) to carry out specified duties related to performance improvement and measurement. These duties include, among others, priority setting, measure endorsement, measure maintenance, and annual reporting to Congress.

Relevant Legislation

- **MIPPA, Section 183,** transferred, from the Medicare HI and SMI Trust Funds, a total of $10 million for each of FY2009 through FY2012 to carry out the activities under SSA Section 1890.
- **American Taxpayer Relief Act of 2012 (ATRA; P.L. 112-240), Section 609(a),** transferred $10 million for FY2013 and modified the duties of the consensus-based entity.
- **Pathway for SGR Reform Act of 2013 (PSRA; P.L. 113-67), 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.
- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Section 1401,** transferred $1,069,000 for the period beginning October 1, 2019, and ending November 21, 2019.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Section 1401,** transferred $1,665,000 for the period beginning October 1, 2019, and ending December 20, 2019.
- **Further Consolidated Appropriations Act, 2020, Division N, Section 102,** transferred $4,830,000 for the period beginning October 1, 2019, and ending May 22, 2020.
- **CARES Act, Section 3802,** provided $20 million for FY2020, which supersedes the funding previously provided by law for all periods of FY2020. Additionally,

funding was provided for a specified portion of FY2021 (October 1, 2020 through November 30, 2020) at the same proportional share of amounts provided during that same period in FY2020.

Current Status

Funding authorized under the CARES Act to support the contract with the consensus-based entity under SSA Section 1890 expires after November 30, 2020.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas (SSA §1848(q)(11); 42 U.S.C. §1395w–4(q))(11)

Current Law

MACRA made several fundamental changes to how Medicare pays for physician and practitioner services by (1) changing the methodology for determining the annual updates to the conversion factor, (2) establishing new methods for paying for professional services under Medicare Part B, including a merit-based incentive payment system (MIPS) to consolidate and replace several existing incentive programs and to apply value and quality adjustments to the Medicare physician fee schedule (MPFS), and (3) establishing the development of, and participation in, alternative payment models (APMs).[9]

To provide technical assistance to small practices and practices in health professional shortage areas, MACRA required the HHS Secretary to enter into contracts or agreements with appropriate entities (such as quality-improvement organizations, regional extension centers, or regional health collaboratives) to offer guidance and assistance to MIPS-eligible professionals in practices of 15 or fewer professionals. Under the technical assistance program, priority is required to be given to professionals located in rural areas, health professional shortage areas, or practices with low composite scores under the new payment system. The guidance and assistance is provided with respect to the MIPS performance categories or with respect to how to transition to the implementation of and participation in an APM.

For purposes of implementing the technical assistance program, $20 million from the SMI Trust Fund was made available to the Centers for Medicare & Medicaid Services (CMS) for each of FY2016-FY2020. These amounts are available until expended.

Relevant Legislation

- **MACRA, Section 101,** provided for the transfer of $20 million, for each of FY2016 through FY2020, from the Medicare SMI Trust Fund.

Current Status

No funds to support the technical assistance program have been authorized beyond FY2020.

[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).*

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 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

- **MMA, Section 412,** provided for an increase in the work geographic index to 1.0 (floor) for any locality for which the work geographic index was less than 1.0 for services furnished from January 1, 2004, through December 31, 2006.
- **TRHCA, Section 102,** extended the floor through 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.
- **Further Consolidated Appropriations Act, 2020, Division N, Section 101,** extended the floor through March 22, 2020.
- **CARES Act, Section 3801,** extended the floor through November 30, 2020.

Current Status

The authority for the MPFS GPCI floor expires after November 30, 2020.

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

Background

Federally certified home health (HH) agencies receive increased payments under the HH prospective payment system (PPS) for Medicare home health care episodes furnished to beneficiaries in rural areas. Before BBA 2018, when provided by legislation, the HH *rural add-on* was a fixed percentage increase to the HH PPS that was applied uniformly to Medicare home health episodes of care provided in rural counties.

Under BBA 2018, the add-on was applied unvaryingly for the first year the legislation extended the increased payment, providing a 3% rural add-on payment to Medicare home health episodes furnished in any rural county that began in CY2018. After CY2018, BBA 2018 provided home health agencies a 3%, 2%, and 1% HH PPS add-on payment for services furnished in rural counties beginning during CY2019-CY2021, respectively, unless the Medicare home health services were, or are, furnished in a rural county with one of the two below-described designations, in which case alternative add-on payments were/are provided:

- For home health episodes furnished to beneficiaries who reside in *low population density* counties, which are defined as rural counties that have a population density of six or fewer individuals per square mile, BBA 2019 provided 4%, 3%, 2%, and 1% HH PPS add-on payments for services beginning during CY2019-CY2022, respectively, and
- For home health episodes provided to beneficiaries who reside in *high utilization* counties, which are defined as rural counties in the top quartile of all counties rendering home health services (by the number of HH episodes furnished per 100 Medicare eligibles), BBA 2018 provided 1.5% and 0.5% HH PPS add-on payments for home health episodes beginning in CY2019-CY2020, respectively. BBA 2018 provided no add-on payment for episodes furnished in high utilization rural counties that begin in CY2021 or CY2022.

Under BBA 2018, rural counties were to be categorized only once and such determination applies to payment home health episodes through CY2022.[10]

Relevant Legislation

- **The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000; P.L. 106-554), Section 508,** established a 10% add-on to Medicare's HH PPS rates for home health episodes provided to beneficiaries in rural areas beginning April 1, 2001, through March 31, 2003.
- **Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173), Section 421,** provided a 5% add-on for services beginning April 1, 2004, through March 31, 2005.

[10] Rural-add-on-payment designations by county can be found at CMS, *Home Health Agency (HHA) Center*, https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.

- **Deficit Reduction Act of 2005 (DRA; P.L. 109-171), Section 5201,** provided a 5% add-on for services beginning January 1, 2006, through December 31, 2006.
- **ACA Section, 3131,** provided a 3% add-on for services beginning April 1, 2010, through December 31, 2015.
- **MACRA, Section 210,** provided a 3% add-on for services beginning January 1, 2016 through December 31, 2017.
- **BBA 2018, Section 50208,** provided a 3% add-on for services beginning in CY2018. BBA 2018 provided a 3%, 2%, and 1% add-on for services beginning in years CY2019-CY2021, respectively, unless the services were provided in a low population density or high utilization rural county. For services provided in low population density rural counties, BBA 2018 provided an add-on at 4%, 3%, 2%, and 1% for services beginning in years CY2019-CY2022, respectively. For services furnished in high utilization rural counties, a 1.5% and 0.5% add-on was provided for services beginning in years CY2019-CY2020, respectively.

Current Status

After December 31, 2020, home health agencies are no longer set to receive an add-on payment for services provided in rural counties designated as high utilization counties.

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 the CARES Act through November 30, 2020, 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.

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.
- **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.[11]

- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Section 1402,** extended authority for these programs through November 21, 2019. For October 1, 2019 to November 21, 2019, they provided a total of $5.343 million in the following amounts: SHIPs, $1.852 million; AAAs $1.069 million; ADRCs, $712,000; and the contract with the National Center for Benefits Outreach and Enrollment, $1.710 million.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Section 1402,** extended authority for these programs through December 20, 2019. For November 22, 2019 to December 20, 2019, they provided a total of $2.98 million in the following amounts: SHIPs, $1.033 million; AAAs $597,000; ADRCs, $397,000; and the contract with the National Center for Benefits Outreach and Enrollment, $953,000.
- **Further Consolidated Appropriations Act, 2020, Division N, Section 103,** extended authority for these programs through May 22, 2020. For December 21, 2019 to May 22, 2020, it provided a total of $15.823 million in the following amounts: SHIPs, $5.485 million; AAAs $3.165 million; ADRCs, $2.110 million; and the contract with the National Center for Benefits Outreach and Enrollment, $5.063 million.
- **CARES Act, Section 3803,** extended authority for these programs through November 30, 2020. For FY2020, it provided a total of $37.5 million in the following amounts (which supersedes the funding previously provided by law for all periods of FY2020): SHIPs, $13 million; AAAs $7.5 million; ADRCs, $5 million; and the contract with the National Center for Benefits Outreach and Enrollment, $12 million. Additionally, funding was provided for these programs for a specified portion of FY2021 (October 1, 2020 through November 30, 2020) at the same proportional share of amounts provided for FY2020.

Current Status

Funding authorized under the CARES Act for low-income outreach and assistance programs will expire after November 30, 2020. However, funds appropriated will be available for obligation until expended.

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

SSA Title XIX: Medicaid

Protection for Recipients of Home and Community-Based Services Against Spouse Impoverishment (SSA §1924; 42 U.S.C. 1396r-5 note)

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, 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.

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[12] See Centers for Medicare & Medicaid Services (CMS), *2020 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.

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

- **The Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Section 2,** extended this provision through September 30, 2019.
- **The Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 3,** extended this provision through December 31, 2019.
- **Further Consolidated Appropriations Act, 2020**, **Section 204,** extended this provision through May 22, 2020.
- **CARES Act, Section 3812,** further extended this provision through November 30, 2020.

Current Status

The authority for the extension of spousal impoverishment protections for certain Medicaid HCBS recipients will expire after November 30, 2020.

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

Increase to Enhanced Federal Medical Assistance Percentage (E-FMAP) (SSA §2105(b); 42 U.S.C. §1397ee(b))

Background

The federal government's share of CHIP expenditures (including both services and administration) is determined by the enhanced federal medical assistance percentage (E-FMAP) rate. The E-FMAP rate is based on the federal medical assistance percentage (FMAP) rate, which is the federal matching rate for the Medicaid program.[15] The FMAP formula compares each state's average per capita income with average U.S. per capita income. FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%.

The E-FMAP rate is calculated by reducing the state share under the regular FMAP rate by 30%. Statutorily, the E-FMAP (or federal matching rate) can range from 65% to 85%. For some CHIP expenditures, the federal matching rate is different from the E-FMAP rate. For instance, the matching rate for translation and interpretation services is the higher of 75% or states' E-FMAP rate plus 5 percentage points. Also, for services provided to children with family incomes exceeding 300% of the federal poverty level (FPL) with an exception for certain states, the matching rate is the lower regular FMAP rate.

Relevant Legislation

- **ACA, Section 2101,** included a provision to increase the E-FMAP rate by 23 percentage points (not to exceed 100%) for most CHIP expenditures from FY2016 through FY2019.
- **Making further continuing appropriations for the fiscal year ending September 30, 2018, and for other purposes (P.L. 115-120), Section 3005,** extended the increase to the E-FMAP rate for one year through FY2020.

[15] Section 6008 of the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) provides an increase to the FMAP rate of 6.2 percentage points for each calendar quarter occurring during the COVID-19 public health emergency period. The FFCRA-increased FMAP rates will be used to calculate the E-FMAP rates for CHIP, which will increase the E-FMAP rates but not by the same amount.

However, for FY2020 the increase to the E-FMAP is 11.5 percentage points instead of 23 percentage points.

Current Status

The increase to the E-FMAP expires after September 30, 2020.

Public Health Service Act (PHSA)

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, the last year where final appropriations data are available.

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.
- **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 billion in FY2019.
- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Division B, Section 1101,** provided $569,863,014 for the period of October 1, 2019 through November 21, 2019.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Division B, Section 1101,** struck the amount that had been provided in P.L. 116-59 and provided $887,671,223 for the period of October 1, 2019 through December 20, 2019.

- **Further Consolidated Appropriations Act, 2020, Division N, Section 401,** struck the amount that had been provided in P.L. 116-69, and provided $2,575,342,466 for the period of October 1, 2019 through May 22, 2020.
- **CARES Act, Section 3831,** provided $4 billion for FY2020, which supersedes the funding previously provided by law for all periods of FY2020. Additionally, $668,493,151 was provided for the period of October 1, 2020 through November 30, 2020.

Current Status

Funding authorized under the CARES Act for CHCF expires after November 30, 2020. Any unused portion of grants awarded for a given fiscal year prior to November 30, 2020, will remain 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.
- **BIPA 2000, Section 931,** increased each program's annual appropriations to $70 million for FY2001 through FY2002 and provided $100 million for FY2003.
- **An Act to Amend the Public Health Service Act with Respect to Special Diabetes Programs for Type 1 Diabetes and Indians (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 for each program through FY2009.
- **MIPPA, Section 303,** provided $150 million each program through FY2011.
- **MMEA, Section 112,** provided $150 million each program through FY2013.
- **ATRA, Section 625,** provided $150 million each program through FY2014.
- **PAMA, Section 204,** provided of $150 million each program through FY2015.
- **MACRA, Section 213,** provided $150 million each program 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.)

- **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, 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.
- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Division B, Section 1102**, provided $ 21,369,863 for each program for the period of October 1, 2019 through November 21, 2019.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Division B, Section 1102**, struck the amount that had been provided in P.L. 116-59 and provided $ 33,287,671 for each program for the period of October 1, 2019 through December 20, 2019.
- **Further Consolidated Appropriations Act, 2020, Division N, Section 402,** struck the amount that had been provided in P.L. 116-69, and provided $96,575,342 for each program for the period of October 1, 2019 through May 22, 2020.
- **CARES Act, Section 3832,** provided $150 million for FY2020 for each program, which supersedes the funding previously provided by law for all periods of FY2020. Additionally, $ 25,068,493 was provided for each program for the period of October 1, 2020 through November 30, 2020.

Current Status

Funding authorized under the CARES Act for the two special diabetes programs expires after November 30, 2020. Any unused portion of grants awarded for a given fiscal year prior to November 30, 2020, will remain 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, the last years where final appropriations data are available.

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.
- **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 Section 3101,** funded $65 million for the first and second quarters of FY2018 for the NHSC.
- **BBA 2018, Section 50901,** replaced language that had provided two-quarters of funding and funded $310 million for each of FY2018 and FY2019 for the NHSC.
- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Division B, Section 1101**, provided $18,021,918 for the period of October 1, 2019 through November 21, 2019.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Division B, Section 1101**, struck the amount that had been provided in P.L. 116-59 and provided $28,072,603 for the period of October 1, 2019 through December 20, 2019.
- **Further Consolidated Appropriations Act, 2020, Division N, Section 401,** struck the amount that had been provided in P.L. 116-69, and provided $81,445,205 for the period of October 1, 2019 through May 22, 2020.
- **CARES Act, Section 3831,** provided $310 million for FY2020, which supersedes the funding previously provided by law for all periods of FY2020. Additionally, $51,808,219 was provided for the period of October 1, 2020 through November 30, 2020.

Current Status

Funding authorized under the CARES Act for the CHCF component of the NHSC expires after November 30, 2020. Any unused portion of grants awarded for a given fiscal year prior to November 30, 2020, will remain available until expended.

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

Background

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

Relevant Legislation

- **ACA, Section 5508,** 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,** provided $15 million for the first quarter of FY2018 for direct and indirect GME payments for teaching health centers.
- **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, Section 3101,** 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,** 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.
- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Division B, Section 1101**, provided $44,164,384 or the period of October 1, 2019 through November 21, 2019.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Division B, Section 1101**, struck the amount that had been provided in P.L. 116-59 and provided $68,794,521 for the period of October 1, 2019 through December 20, 2019.
- **Further Consolidated Appropriations Act, 2020**, **Division N, Section 401,** struck the amount that had been provided in P.L. 116-69, and provided $ 199,589,041 for the period of October 1, 2019 through May 22, 2020.
- **CARES Act, Section 3831,** provided $126.5 million for FY2020, which supersedes the funding previously provided by law for all periods of FY2020. Additionally, $21,141,096 was provided for the period of October 1, 2020 through November 30, 2020.

Current Status

Funding authorized under the CARES Act for Teaching Health Center GME payments expires after November 30, 2020, but unused funds remain available until expended.

Other CY2020 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.C. 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.
- **Further Consolidated Appropriations Act, 2020, Section 146,** established a new sunset date of before January 1, 2021.

Current Status

Authorization for the HCTC is scheduled to expire after December 31, 2020.

CY2019 Expired Provisions

Pregnancy Assistance Fund

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

Background

The Pregnancy Assistance Fund (PAF) program focuses on meeting the educational, social service, and health needs of vulnerable expectant and parenting individuals and their families during pregnancy and the postnatal period. The program identifies eligible populations as expectant and parenting teens, college students, and women of any age who experience domestic violence, sexual violence, sexual assault, or stalking. HHS administers the PAF program, and funding is awarded competitively to the 50 states, DC, U.S. territories, and tribal entities (hereinafter, grantees) that apply successfully. Grantees may use funds (1) to establish, operate, or maintain pregnancy or parenting services at institutions of higher education (IHEs), high schools, or community service providers; (2) to provide, in partnership with the state attorney general's office, certain legal and supportive services for women who experience domestic violence, sexual violence, sexual assault, or stalking while they are pregnant or parenting an infant; and (3) to support, either directly or through a subgrantee, public awareness about PAF services for the expectant and parenting population that is eligible for the program.

Relevant Legislation

- **ACA, Section 10212**, established PAF and provided $25 million annually from FY2010 through FY2019.

Current Status

Funding authorized under the ACA expired after September 30, 2019.

SSA Title VXIII: Medicare

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.[16] To implement the payment modifications in Section 101 of MACRA, the law authorized the transfer of $80 million from the SMI Trust Fund for each fiscal year beginning with FY2015 and ending with FY2019. The amounts transferred are to be available until expended.

[16] 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).*

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.

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 MIPS 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 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.

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 section "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))."

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 expired 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

- **The 21st Century Cures Act (Cures Act; P.L. 114-255), 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 HHS Secretary 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 expired for discharges occurring in cost reporting periods during FY2020 and for subsequent years.

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 expired after December 31, 2019.

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 second session of the 116th Congress (i.e., during calendar year [CY] 2020). 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.[17] This appendix also includes 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 extended in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136). No relevant demonstration projects and pilot programs within the same scope expired during the first session of the 116th Congress (i.e., during CY2019).

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 2020.

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

(CY2020)

Expires After	Health Care-Related Program	Provision		Contact
11/30/2020	Medicaid/Other	Demonstration to Improve Community Behavioral Health Clinics[a]	PAMA §223(f) 42 U.S.C. §1396a	Alison Mitchell
11/30/2020	Medicaid	Money Follows the Person Rebalancing Demonstration[b]	DRA §6071 42 U.S.C. §1396a note	Kirsten Colello
11/30/2020	Other	Demonstration Projects to Address Health Professions Workforce Needs[c]	SSA §2008(c) 42 U.S.C. §1397g[d]	Elayne Heisler
12/31/2020	Medicare	Medicare Independence at Home Demonstration Program[e]	SSA §1866 42 U.S.C. §1395cc–5	Jim Hahn
12/31/2020	Medicare	Medicare IVIG Access Demonstration[f]	SSA §1833 42 U.S.C. §1395l	Cliff Binder

Source: Congressional Research Service.

[17] 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.

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

a. Extended, expanded, and amended most recently by Section 3814 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136). For more information, see https://www.samhsa.gov/section-223.

b. Extended most recently by Section 3811 of the CARES Act. For more information, see https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html.

c. Extended most recently by Section 3823 of the CARES Act. 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).

e. Extended most recently in Section 50301of the Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-123). For more information, see https://innovation.cms.gov/innovation-models/independence-at-home.

f. Extended most recently in Section 302 of the Disaster Tax Relief and Airport and Airway Extension Act of 2017 (P.L. 115-63). For more information, see https://innovation.cms.gov/innovation-models/ivig.

Appendix B. Provisions Included in the Previous CRS Health Care-Related Expiring Provisions Report

This appendix provides information on the provisions that were included in the previous CRS report on health care-related expiring provisions (CRS Report R45781, *Health Care-Related Expiring Provisions of the 116th Congress, First Session*) henceforth referred to as "R45781," but were not detailed in the body of this report.

As does the current report, R45781 included expiring provisions (of the same two types discussed herein) related to Medicare, Medicaid, State Children's Health Insurance Program (CHIP), and private health insurance programs and activities as well as selected other health care-related provisions. R45781 included health care-related provisions that were enacted in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) or, at the time of publication, had been extended under the Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-123). R45781 also described health care-related provisions that, at the time of publication, were set to expire during the first session of the 116th Congress (i.e., during calendar year [CY] 2019) or had expired during the 115th Congress (i.e., during CY2017 or CY2018).

Some of the provisions detailed in R45781 fell within the scope of this report. Such provisions expired in CY2019 or were extended and are set to expire in CY2020. Table B-1 includes the provisions detailed in R45781 that remain expired or were extended to dates beyond the 116th Congress (i.e., after CY2020). The third column in Table B-1 provides each provision's expiration date as it was in R45781. The fourth column reflects updated information, indicating whether the expiration date remains "unchanged" by law or providing the current expiration date for provisions extended pursuant to congressional modification.

Two private health insurance provisions were included in R45781 that did not meet the report criteria but were set to expire in 2019. These provisions modified fees and taxes established by the ACA to help fund ACA activities, including those related to private health insurance. As reflected in Table B-1, those fee and tax provisions were permanently repealed in the Further Consolidated Appropriations Act, 2020 (P.L. 116-94).

Unlike the other provisions that were included in R45781 and were extended past CY2020, the extension for the Patient-Centered Outcomes Research Trust Fund (PCORTF) was legislatively undertaken in a manner that resulted in significant revisions to the program and/or funding mechanisms detailed in R45781. Because of this, this appendix includes an updated provision summary below Table B-1. See, "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)." For more detailed background information on the other provisions included in Table B-1, see CRS Report R45781, *Health Care-Related Expiring Provisions of the 116th Congress, First Session*.

Table B-1 does not include demonstration projects or pilot programs. The only project or program in Appendix A of R45781 that was not included in this report is the Demonstration Program to Increase Access to Dental Health Care Service. The demonstration program expired after March 23, 2017.

Table B-1. Provisions Included in the Previous CRS Health Care-Related Expiring Provisions Report That Were Not Included in This Report

Health Care-Related Program	Provision		Expiration Date as of CRS Report R45781, *Health Care-Related Expiring Provisions of the 116th Congress, First Session*	Current Expiration Date
Medicare	Delay in Applying the 25% Patient Threshold Payment Adjustment for Long-Term Care Hospitals	MMSEA §114(c) 42 U.S.C. §1395ww note	9/30/2017	Unchanged
Medicare	Long-Term Care Hospital Moratoria	MMSEA §114(d) 42 U.S.C. §1395ww note	9/30/2017	Unchanged
Medicare	Extension of Enforcement Instruction on Supervision Requirements for Outpatient Therapeutic Services in Critical Access and Small Rural Hospitals	P.L. 113-198	12/31/2017	Unchanged
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)	9/30/2018	Unchanged
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)	12/31/2018	Unchanged
Medicare	Delay in Authority to Terminate Contracts for MA Plans Failing to Achieve Minimum Quality Ratings	SSA §1857 42 U.S.C. §1395w-27	12/31/2018	Unchanged
Medicaid	Additional Medicaid Funding for the Territories	SSA §1108 42 U.S.C. §1308	9/30/2019	9/30/2021
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)	9/30/2019	Unchanged
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	9/30/2019	9/30/2029[a]
Other	Family-to-Family Health Information Centers	SSA §501(c) 42 U.S.C. §701(c)(1)(A)(iii)	9/30/2019	9/30/2024
Private Health Insurance	Suspension of the Annual Fee on Health Insurance Providers	ACA §9010	12/31/2019	Tax permanently repealed[b]

Health Care-Related Program	Provision		Expiration Date as of CRS Report R45781, *Health Care-Related Expiring Provisions of the 116th Congress, First Session*	Current Expiration Date
Private Health Insurance	Moratorium on the Excise Tax on Medical Device Manufacturers	26 U.S.C. §4191	12/31/2019	Tax permanently repealed[b]

Source: Congressional Research Service.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148. as amended), ASC = Ambulatory Surgery Centers, IRC = Internal Revenue Code, LTCH= Long-Term Care Hospital, MA = Medicare Advantage, MMSEA = Medicare, Medicaid, and SCHIP Extension Act of 2007, SSA = Social Security Act, U.S.C. = *U.S. Code*.

a. Unlike the other provisions that were included in R45781 and were extended past CY2020, the extension for the Patient-Centered Outcomes Research Trust Fund was legislatively undertaken in a manner that resulted in significant revisions to the program and/or funding mechanisms detailed in R45781. Because of this, the instant appendix includes an updated provision summary below Table B-1. See, "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)." For more detailed background information on the other provisions included in Table B-1, see CRS Report R45781, *Health Care-Related Expiring Provisions of the 116th Congress, First Session*.

b. Two private health insurance provisions were included in R45781 that did not meet the report criteria, but the provisions were set to expire in 2019. Both provisions modify fees and taxes established by the ACA to help fund ACA activities, including those related to private health insurance. The 'Excise Tax on Medical Device Manufacturers' and the 'Annual Fee on Health Insurance Providers' were permanently repealed by sections 501 and 502 respectively of Division N of the Further Consolidated Appropriations Act, 2020 (P.L. 116-94).

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 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 policies 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,** 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). Under this provision, PCORTF was to terminate on September 30, 2019.
- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59), Section 1403,** extended the termination date of PCORTF through November 21, 2019.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69), Section 1403,** further extended the termination date of PCORTF through December 20, 2019.
- **Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Division N, Section 104,** extends funding for PCORTF through FY2029 by appropriating both the amount equivalent to the net revenues received from the fees on health insurance policies and self-insured plans and providing a direct appropriation in a specified amount (the "applicable amount") for each of fiscal years 2020 through 2029. The transfers from the Medicare HI and SMI Trust Funds were not extended. The section extends the termination date of PCTORF through FY2029; extends the termination dates of the fees on health insurance policies and self-insured plans through FY2029; and extends the requirement that 20% of PCORTF funds be transferred to the HHS Secretary for carrying out PHSA Section 937 for each fiscal year through FY2029. The section also makes modifications to the authorizing language for PCORI relating to the composition of its Board; appointments to its Methodology Committee; and the identification of research priorities, among others.

Current Status

Appropriated funds to PCORTF expire after September 30, 2029. 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, 2029, and any amounts in the Trust Fund after such date shall be transferred to the general fund of the Treasury.

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

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

P.L. Number	Abbreviation	Act Title
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. 106-554	BIPA 2000	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
P.L. 107-210	—	The Trade Act of 2002
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. 108-89	—	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. 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. 110-173	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. 111-5	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. 111-309	MMEA	Medicare and Medicaid Extenders Act of 2010
P.L. 112-40	—	The Trade Adjustment Assistance Extension Act of 2011
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. Number	Abbreviation	Act Title
P.L. 113-67	PSRA	Continuing Appropriations Resolution of 2014, which includes Division B, the Pathway for SGR Reform Act of 2013
P.L. 113-93	PAMA	Protecting Access to Medicare Act of 2014
P.L. 114-10	MACRA	Medicare Access and CHIP Reauthorization Act of 2015[i]
P.L. 114-27	—	The Trade Preferences Extension Act of 2015
P.L. 114-115	PAMPA	Patient Access and Medicare Protection Act
P.L. 114-255	Cures Act	The 21st Century Cures Act
P.L. 115-63	—	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
P.L. 116-39	—	The Sustaining Excellence in Medicaid Act of 2019
P.L. 116-59	—	Continuing Appropriations Act, 2020, and Health Extenders Act of 2019
P.L. 116-69	—	Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019
P.L. 116-94	—	Further Consolidated Appropriations Act, 2020
P.L. 116-127	FFCRA	Families First Coronavirus Response Act[j]
P.L. 116-136	CARES Act	Coronavirus Aid, Relief, and Economic Security Act

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)*.

j. See CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*.

Appendix D. List of Abbreviations

AAA: Area Agencies on Aging

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

ACL: Administration for Community Living

ADRC: Aging and Disability Resource Center

AHRQ: Agency for Healthcare Research and Quality

APM: Alternative payment model

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

BBA 2018: Bipartisan Budget Act of 2018 (P.L. 115-123)

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

CARES Act: Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136)

CHCF: Community Health Center Fund

CHIP: State Children's Health Insurance Program

CMS: Centers for Medicare & Medicaid Services

CRS: Congressional Research Service

CY: Calendar year

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

DRG: Diagnosis related group

E-FMAP: Enhanced federal medical assistance percentage

FFCRA: Families First Coronavirus Response Act (P.L. 116-127)

FMAP: Federal medical assistance percentage

FPL: Federal poverty level

FY: Fiscal year

GME: Graduate medical education

GPCI: Geographic Practice Cost Index

HCBS: Home and community-based services

HCTC: Health Coverage Tax Credit

HH: Home health

HHS: Department of Health and Human Services

HI: Hospital Insurance

IHE: Institution of higher education

IHS: Indian Health Service

IPPS: Medicare Inpatient Prospective Payment System

IVIG: Intravenous immune globulin

LTCH: Long-term care hospital

LTCH PPS: Long-term care hospital prospective payment system

LTSS: Long-term services and supports

MA: Medicare Advantage

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)

MedPAC: Medicare Payment Advisory Commission

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

MIPS: Merit-based incentive payment system

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

MSP: Medicare Savings Program

NHSC: National Health Service Corps

NQF: National Quality Forum

PAF: Pregnancy Assistance Fund

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

PETI: Post-eligibility treatment of income

PHSA: Public Health Service Act

PPS: Prospective payment system

PREIS: Personal Responsibility Education Program Innovative Strategies

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

SHIP: State Health Insurance Assistance Program

SMI: Supplementary Medical Insurance

SNAP: Supplemental Nutrition Assistance Program

SRAE: Sexual Risk Avoidance Education

SSA: Social Security Act

SSI: Supplemental Security Income

TAA: Trade Adjustment Assistance

TANF: State Temporary Assistance for Needy Families

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

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

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

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

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

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

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