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Bipartisan Budget Act of 2018 (P.L. 115-123): Brief Summary of Division E—The Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act

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Summary

On February 9, 2018, President Donald Trump signed into law the Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-123). Division E of that law is titled the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act. This report provides a brief summary of each of the provisions included in the ACCESS Act, along with the contact information for the CRS expert who can answer questions about each provision. Division E consists of 12 titles. Each title is addressed in a separate table, and the provisions are discussed in the order they appear in the law. Topics discussed in this report include Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), public health, child and family services, foster care, social impact partnerships, child support enforcement, and prison data reporting.

Subsequent CRS reports examining selected subsets of these provisions will be linked to this report as they become available.

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Introduction

This report briefly summarizes the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, enacted February 9, 2018, as Division E of the Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-123).

The provisions discussed in this report are part of a larger legislative package that was enacted to address a number of issues before Congress, including the need for an extension of temporary appropriations set to expire on February 8, 2018. An early version of this package was added by the House to H.R. 1892 (an unrelated measure), in the form of an amendment to an amendment that had been previously adopted by the Senate during its consideration of H.R. 1892. The House adopted its amendment on February 6, 2018, by a vote of 245-182. The Senate subsequently took up the House proposal and adopted a further amendment to it on February 9, by a vote of 71-28. The House agreed to the Senate actions that same day by a vote of 240-186. The final version of H.R. 1892, enacted as the Bipartisan Budget Act of 2018 (P.L. 115-123), contained FY2018 temporary continuing appropriations, FY2018 supplemental appropriations, an increase to the debt limit, increases to the statutory spending limits for FY2018 and FY2019, tax provisions, and numerous provisions extending or making changes to mandatory spending programs, among other topics.

According to the Congressional Budget Office (CBO) cost estimate, Division E of BBA 2018 is estimated to increase direct spending outlays by a total of $829 million, and increase on- and off-budget revenues by a total of $4.6 billion, for a net savings of $3.8 billion over the period of FY2018 through FY2027.[1]

The topics specifically addressed in this report include the following:

- Medicare (**Table 2**, **Table 3**, **Table 4**, **Table 10**, **Table 11**, and **Table 12**)
- State Children's Health Insurance Program (CHIP) (in **Table 1**)
- Public Health Extenders (in **Table 5** and **Table 9**)
- Children and Family Services (in **Table 6**)
- Foster Care (in **Table 7**)
- Social Impact Partnerships Program (in **Table 8**)
- Medicaid and Offsets (in **Table 12**)

Along with the brief description of each provision in Division E, this report provides the contact information for the CRS analysts who can answer further questions. CRS is preparing additional reports analyzing subsets of these provisions by topic or program in greater detail. Those reports will be linked to this report as they become available.

Abbreviated Summary of Provisions

Division E begins with a short title (Section 50100), Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act. Division E is divided into twelve titles. The tables below briefly describe the sections within each title and provide CRS contacts.

[1] Congressional Budget Office, *Estimated Direct Spending and Revenue Effects of Division E of Senate Amendment 1930, the Bipartisan Budget Act of 2018*, February 8, 2018, at https://www.cbo.gov/publication/53557.

Table 1. Title I (CHIP): Description and CRS Contact Information, by Section

Section Number	Section Title	Description of Section	Contact
50101(a and b)	Funding Extension of the Children's Health Insurance Program Through Fiscal Year 2027	Section 50101(a) extends federal CHIP funding for four years by adding federal mandatory appropriations for FY2024 through FY2027. Section 50101(b) authorizes CHIP allotments for FY2024 through FY2027.	Alison Mitchell 7-0152 amitchell@crs.loc.gov
50101(c)	Extension of Child Enrollment Contingency Fund	Section 50101(c) extends the funding mechanism for the Child Enrollment Contingency Fund and payments from the fund for the period of FY2024 through FY2027.	Alison Mitchell 7-0152 amitchell@crs.loc.gov
50101(d)	Extension of Qualifying States Option	Section 50101(d) extends the qualifying states option for the period of FY2024 through FY2027.	Alison Mitchell 7-0152 amitchell@crs.loc.gov
50101(e)	Extension of Express Lane Eligibility Option	Section 50101(e) extends the express lane eligibility option for the period of FY2024 through FY2027.	Evelyne Baumrucker 7-8913 ebaumrucker@crs.loc.gov
50101(f)	Assurance of Eligibility Standard for Children and Families	Section 50101(f) extends the assurance of eligibility standard for children and families for the period of FY2024 through FY2027.	Evelyne Baumrucker 7-8913 ebaumrucker@crs.loc.gov
50102	Extension of Pediatric Quality Measures Program	Section 50102 appropriates $60 million in mandatory funds for the period of FY2024 through FY2027 to carry out specified pediatric quality measure activities, including maintenance of a core quality measure set, identification of measure gaps, and development of measures. The section makes annual state reporting of the pediatric core measure set mandatory and modifies the reporting requirement from the HHS Secretary to Congress to include the status of mandatory reporting by states.	Amanda Sarata 7-7641 asarata@crs.loc.gov
50103	Extension of Outreach and Enrollment Program	Section 50103 extends the outreach and enrollment program for four years by adding federal mandatory appropriations in the amount of $48 million for the period FY2024 through FY2027 and provides direction for the use of such funds.	Evelyne Baumrucker 7-8913 ebaumrucker@crs.loc.gov

Source: CRS analysis of Title I (CHIP) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (PP.L. 115-123).

Notes: CHIP = State Children's Health Insurance Program; HHS = Department of Health and Human Services.

Table 2. Title II (Medicare Extenders): Description and CRS Contact Information, by Section

Section Number	Section Title	Description of Section	Contact
50201	Extension of Work GPCI Floor	Payments under the Medicare physician fee schedule 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. Section 50201 extends the application of the floor for the GPCI—used to adjust physician work for any locality for which the work GPCI is less than the national average—for two years, from January 1, 2018, through December 31, 2019.	Jim Hahn 7-4914 jhahn@crs.loc.gov
50202	Repeal of Medicare Payment Cap for Therapy Services; Limitation to Ensure Appropriate Therapy	Medicare beneficiaries face annual payment limits for all Medicare-covered outpatient therapy services. An exceptions process, allowing providers and practitioners to request an exception on a beneficiary's behalf when those services are reasonable and necessary, expired on December 31, 2017. Section 50202 permanently repeals the outpatient therapy caps beginning January 1, 2018, and makes modifications to the requirements for indicating medical necessity and the conditions for medical review.	Jim Hahn 7-4914 jhahn@crs.loc.gov
50203	Medicare Ambulance Services	Section 50203 extends the Medicare urban, rural, and super-rural add-on payments for ambulance transports for an additional five years (CY2018 through CY2022), requires development of a cost-information collection system, and directs MedPAC to evaluate the system.	Marco Villagrana 7-3509 mvillagrana@crs.loc.gov
50204	Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals	Section 50204 extends the Medicare inpatient payment adjustment for LVHs for five years, from FY2018 through FY2022; modifies the definition of an LVH for four years, from FY2019 through FY2022; and requires MedPAC to assess the effect of the Medicare low-volume adjustment.	Marco Villagrana 7-3509 mvillagrana@crs.loc.gov
50205	Extension of the Medicare-Dependent Hospital (MDH) Program	Section 50205 extends and modifies the MDH program for five years (FY2018 through FY2022) and directs GAO to assess the MDH program.	Marco Villagrana 7-3509 mvillagrana@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
50206	Extension of Funding for Quality Measure Endorsement, Input, and Selection; Reporting Requirements	Section 50206(a) transfers from the Hospital Insurance and Supplementary Medical Insurance Trust Funds $7.5 million for each of FY2018 and FY2019 to support selected activities, including the pre-rulemaking process for consideration of inclusion of quality measures in Medicare quality programs and a contract with the NQF to carry out specific performance measurement-related activities. Sections 50206(b) and (c) add new HHS reporting requirements and modify existing NQF reporting requirements to specify use of funding and itemization of financial information, among other things. Finally, Section 50206(d) directs GAO to report on these health care quality measurement activities.	Amanda Sarata 7-7641 asarata@crs.loc.gov
50207	Extension of Funding and Outreach Assistance for Low-Income Programs; State Health Insurance Assistance Program Reporting Requirements	Section 50207 extends mandatory funding to SHIPs and other entities for two years, FY2018 and FY2019. It also adds a requirement to publicly report federal SHIP funding and other grant information, as specified by the HHS Secretary, by state.	Kirsten Colello 7-7839 kcolello@crs.loc.gov
50208	Extension of Home Health Rural Add-On	Section 50208 extends the Medicare home health rural add-on payment, which is an increase to the episode base rate for home health services provided to beneficiaries in rural areas, for five years, from January 1, 2018, until the end of 2022, though not all rural areas will receive the full add-on for the full five years. The extension includes methodology changes for determining a county's add-on amount starting in 2019. The HHS Inspector General is directed to analyze home health claims.	Phoenix Voorhies 7-9955 pvoorhies@crs.loc.gov

Source: CRS analysis of Title II (Medicare Extenders) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Notes: GAO = Government Accountability Office; GPCI = Geographic Practice Cost Index; HHS = Department of Health and Human Services; LVH = Low-volume hospital; MedPAC = Medicare Payment Advisory Commission; MDH = Medicare-dependent hospital; NQF = National Quality Forum; SHIP = State Children's Health Insurance Program.

Table 3. Title III (Creating High-Quality Results and Outcomes Necessary to Improve Chronic [CHRONIC] Care): Description and CRS Contact Information, by Section

Section Number	Section Title	Description of Section	Contact
50301	Extending the Independence at Home Demonstration Program	Section 50301 makes certain modifications to extend and expand the Medicare Independence at Home demonstration, which tests a payment and service delivery model that uses home-based primary care teams designed to reduce expenditures and improve health outcomes in the care of certain chronically ill Medicare beneficiaries. Under prior law, this program would have ended on September 30, 2017.	Jim Hahn 7-4914 jhahn@crs.loc.gov
50302	Expanding Access to Home Dialysis Therapy	Section 50302 expands the use of telehealth services for Medicare beneficiaries with ESRD undergoing home dialysis, starting in 2019. Beneficiaries would be required to receive a face-to-face clinical assessment without the use of telehealth at least once every three consecutive months for individuals already on dialysis and at least monthly for the initial three months of home dialysis.	Suzanne Kirchhoff 7-0658 skirchhoff@crs.loc.gov
50311	Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations	Section 50311 extends authority for MA SNPs to operate indefinitely. Under prior law, the program was set to expire after December 31, 2018. Section 50311 also adds requirements for dual-eligible and chronic and disabling condition SNPs. Dual-eligible SNPs must better integrate long-term services and supports and/or behavioral health services with state Medicaid agencies, and they must establish procedures to unify the Medicare and Medicaid appeal and grievance processes. For chronic and disabling condition SNPs, the HHS Secretary must develop new care-management requirements and periodically update the definition of individuals with chronic and disabling conditions. GAO is directed to study state-level integration between dual-eligible SNPs and Medicaid.	Cliff Binder 7-7965 cbinder@crs.loc.gov
50321	Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees	Section 50321 requires the HHS Secretary to expand by January 1, 2020, the CMMI MA VBID model from 22 states to all states. Section 50321 prohibits the Secretary from modifying or terminating the VBID model until January 1, 2022. This section also requires the Secretary to allocate CMMI appropriated funds to design, implement, and evaluate the MA VBID model.	Cliff Binder 7-7965 cbinder@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
50322	Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees	Section 50322 grants the HHS Secretary the authority to allow MA plans to offer different supplemental benefits to enrollees who meet the definition of *chronically ill* than the supplemental benefits they offer to other plan enrollees, starting in CY2020. Section 50322 requires the GAO to report to Congress on supplemental benefits under MA plans.	Paulette Morgan 7-7317 pcmorgan@crs.loc.gov
50323	Increasing Convenience for Medicare Advantage Enrollees Through Telehealth	Section 50323 allows MA plans to offer additional telehealth benefits that, for payment purposes, will be treated as if they were benefits required under original Medicare. This policy is effective starting in CY2020.	Paulette Morgan 7-7317 pcmorgan@crs.loc.gov
50324	Providing Accountable Care Organizations the Ability to Expand the Use of Telehealth	Although Medicare covers telehealth services in a variety of settings, current law places certain restrictions on telehealth payments. Section 50324 expands the ability of Pioneer ACOs and certain MSSP models to receive payments for telehealth services in the same manner as Next Generation ACOs, beginning January 1, 2020, and to make other modifications to expand the use of telehealth services. The HHS Secretary is directed to conduct a study on the implementation of this section.	Jim Hahn 7-4914 jhahn@crs.loc.gov
50325	Expanding the Use of Telehealth for Individuals with Stroke	Stroke patients may receive care in a number of sites and across different providers, including physician services, acute-care hospitals (inpatient and/or outpatient), inpatient rehabilitation facilities, or skilled nursing facilities. Section 50325 eliminates the geographic location (originating site) restrictions for telehealth services furnished for the purpose of diagnosing, evaluating, or treating an acute stroke, among other modifications, beginning January 1, 2019.	Jim Hahn 7-4914 jhahn@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
50331	Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization	Initially, Medicare beneficiaries in Parts A or B were assigned retrospectively to an MSSP ACO based on whether the physician who provided the plurality of their primary care services participated in an ACO. Under these original models, beneficiaries did not have the option of choosing to participate directly in an ACO (aside from seeking care from a particular provider). Section 50331 allows MSSP ACOs the choice of prospective assignment, beginning with agreements entered into or renewed on or after January 1, 2020, and beneficiaries are to be able to voluntarily identify an ACO professional as their primary care provider and be assigned to that ACO beginning with the 2018 performance year.	Jim Hahn 7-4914 jhahn@crs.loc.gov
50341	Eliminating Barriers to Care Coordination Under Accountable Care Organizations	Under prior law, beneficiaries who were assigned to or voluntarily elected to be identified with an MSSP ACO continued to have standard Medicare Parts A and B cost-sharing responsibilities, including deductibles and coinsurance payments. Section 50341 authorizes the HHS Secretary to create an ACO Beneficiary Incentive Program intended to encourage beneficiaries to obtain medically necessary primary care services by permitting incentive payments to beneficiaries; the program is to be implemented no earlier than January 1, 2019, and no later than January 1, 2020. HHS is directed to conduct an evaluation of the program.	Jim Hahn 7-4914 jhahn@crs.loc.gov
50342	GAO Study and Report on Longitudinal Comprehensive Care Planning Services Under Medicare Part B	Section 50342 requires GAO to report to Congress on the establishment of a payment code for longitudinal comprehensive care planning services, under Medicare Part B. This code, and accompanying payment (e.g., to a hospice), would be for a beneficiary visit to discuss a care plan that addresses the progression of the disease; treatment options; goals, values, and preferences of the beneficiary; and related issues.	Jim Hahn 7-4914 jhahn@crs.loc.gov
50351	GAO Study and Report on Improving Medication Synchronization	Section 50351 requires GAO to report to Congress on Medicare Part D and private-payer programs to synchronize pharmacy drug dispensing. Prescription synchronization enables patients to fill multiple prescriptions from various providers at the same time to improve medication adherence.	Suzanne Kirchhoff 7-0658 skirchhoff@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
50352	GAO Study and Report on Impact of Obesity Drugs on Patient Health and Spending	Section 50352 requires GAO to report to Congress on the use of prescription drugs to control the weight of obese patients, the impact of coverage of such drugs on health and spending, and possible legislative and administrative actions. Medicare Part D now excludes coverage of weight-loss drugs.	Suzanne Kirchhoff 7-0658 skirchhoff@crs.loc.gov
50353	HHS Study and Report on Long-Term Risk Factors for Chronic Conditions Among Medicare Beneficiaries	Section 50353 requires the HHS Secretary to report to Congress on long-term cost drivers to the Medicare program, including obesity, tobacco use, mental health conditions, and other factors that might contribute to the deterioration of health conditions among individuals with chronic conditions in the Medicare population.	Jim Hahn 7-4914 jhahn@crs.loc.gov
50354	Providing Prescription Drug Plans with Parts A and B Claims Data to Promote the Appropriate Use of Medications and Improve Health Outcomes	Section 50354 requires the HHS Secretary to set up a process, by 2020, under which the sponsor of a Part D stand-alone drug plan may request Medicare Parts A and B medical claims data. The data, which are to be as current as possible, may be used to improve medication use and care coordination, and for other purposes approved by the Secretary.	Suzanne Kirchhoff 7-0658 skirchhoff@crs.loc.gov

Source: CRS analysis of Title III (Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Notes: ACO = Accountable Care Organization; CMMI = Center for Medicare & Medicaid Innovation; ESRD = End-stage renal disease; GAO = Government Accountability Office; HHS = Department of Health and Human Services; MA = Medicare Advantage; MSSP = Medicare Shared Savings Program; SNP = Special Needs Plan; VBID = Value-Based Insurance Design.

Table 4. Title IV (Part B Improvement Act and Other Part B Enhancements): Description and CRS Contact Information, by Section

Section Number	Section Title	Description of Section	Contact
50401	Home Infusion Therapy Services Temporary Transitional Payment	Section 50401 authorizes a two-year temporary transitional payment (January 1, 2019, to December 31, 2020) for nursing and other services provided in association with a Home Infusion Benefit authorized in the 21st Century Cures Act (P.L. 114-255) that is otherwise to begin January 1, 2021.	Paulette Morgan 7-7317 pcmorgan@crs.loc.gov
50402	Orthotist's and Prosthetist's Clinical Notes as Part of the Patient's Medical Record	Section 50402 requires the HHS Secretary to recognize documentation created by orthotists and prosthetists as part of a patient's medical record when determining Medicare coverage for prosthetics or orthotics. Historically, documentation created by orthotists and prosthetists has been considered supplementary to the medical record and not sufficient evidence of medical necessity. Medicare payments to orthotists and prosthetists are based on the monetary value of the prosthetic or orthotic provided.	Paulette Morgan 7-7317 pcmorgan@crs.loc.gov
50403	Independent Accreditation for Dialysis Facilities and Assurance of High Quality Surveys	Section 50403 provides that the HHS Secretary may use an approved accreditation agency, in addition to a state agency, to certify that a dialysis facility meets specified criteria to participate in Medicare. The Secretary is to begin considering applications from accreditation agencies that want to provide dialysis facility certification services no later than 90 days after enactment. The provision also sets deadlines for performing an initial assessment of a new dialysis facility.	Suzanne Kirchhoff 7-0658 skirchhoff@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
50404	Modernizing the Application of the Stark Rule Under Medicare	To prevent physicians from referring patients based on financial gain, the Stark law generally provides that if a physician or physician's family member has a financial relationship with an entity, (1) the physician may not make a referral to the entity for the furnishing of designated health services for which payment may be made under Medicare and (2) the entity cannot submit a claim to the program or bill for such services. The Stark law includes numerous exceptions that protect certain common business arrangements. Section 50404 allows an arrangement to meet specified Stark law exceptions, despite a failure to maintain certain written documents, obtain required signatures on certain documents, or renew certain leases or other agreements in a timely manner.	Jennifer Staman 7-2610 jstaman@crs.loc.gov
50411	Making Permanent the Removal of the Rental Cap for Durable Medical Equipment Under Medicare with Respect to Speech Generating Devices	Section 50411 removes a sunset date and permanently requires speech-generating devices to be paid under the "Inexpensive and Other Routinely Purchased Durable Medical Equipment" category, which requires suppliers to be paid a lump-sum payment, rather than the "Capped Rental" category, which requires suppliers to be paid 13 monthly rental payments, after which ownership of the equipment transfers to the beneficiary.	Paulette Morgan 7-7317 pcmorgan@crs.loc.gov
50412	Increased Civil and Criminal Penalties and Increased Sentences for Federal Health Care Program Fraud and Abuse	Section 50412 at least doubles and sometimes quadruples civil money penalties and criminal fines applicable to violations of federal health care program law. Section 50412 also increases the length of criminal prison sentences that may be applied to individuals convicted of federal health program violations. The section applies to acts committed after the date of enactment.	Cliff Binder 7-7965 cbinder@crs.loc.gov
50413	Reducing the Volume of Future EHR-Related Significant Hardship Requests	Section 50413 removes a requirement that the HHS Secretary select more stringent measures of meaningful use over time for both eligible hospitals and eligible professionals under the Medicare EHR Incentive Program.	Amanda Sarata 7-7641 asarata@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
50414	Strengthening Rules in Case of Competition for Diabetic Testing Strips	Section 50414 adds additional oversight requirements to ensure compliance with an existing statutory requirement that suppliers of diabetic testing strips provided through the Medicare mail-order program have available at least 50% of the types of strips found in the market. It adds additional requirements that prohibit test-strip suppliers from influencing beneficiaries to switch the brands of strips they use. This section applies to bids to furnish test strips on or after January 1, 2019.	Paulette Morgan 7-7317 pcmorgan@crs.loc.gov

Source: CRS analysis of Title IV (Part B Improvement Act and Other Part B Enhancements) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Notes: EHR = Electronic health record; HHS = Department of Health and Human Services.

Table 5. Title V (Other Health Extenders): Description and CRS Contact Information, by Section

Section Number	Section Title	Description of Section	Contact
50501	Extension for Family-to-Family Health Information Centers	Section 50501 appropriates $6 million in mandatory funds for each of FY2018 and FY2019 for the Family-to-Family Health Information Centers program, which funds family-staffed and family-run centers that provide information, education, technical assistance, and peer support to families of children (including youth) with special health care needs and health professionals who serve such families. The section also expands the program, which previously had been limited to the 50 states and the District of Columbia, by requiring that, for FY2018 and FY2019, centers be developed in all of the territories and that at least one center be developed for Indian tribes.	Elayne Heisler 7-4453 eheisler@crs.loc.gov
50502	Extension for Sexual Risk Avoidance Education	Section 50502 renames the Abstinence Education program as the Sexual Risk Avoidance Education program and appropriates $75 million in mandatory funds for the program for each of FY2018 and FY2019. It additionally includes revised purpose areas and new requirements on financial allotments, educational elements, research and data, and evaluation.	Adrienne Fernandes-Alcantara 7-9005 afernandes@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
50503	Extension for Personal Responsibility Education	Section 50503 appropriates $75 million in mandatory funds for PREP in each of FY2018 and FY2019. It extends to FY2019 the three-year Competitive PREP grants that were awarded in any of three years: FY2015, FY2016, or FY2017. In addition, it specifies that victims of human trafficking are considered high-risk, vulnerable, and culturally underrepresented youth for purposes of PREP's Personal Responsibility Education Program Innovative Strategies component.	Adrienne Fernandes-Alcantara 7-9005 afernandes@crs.loc.gov

Source: CRS analysis of Title V (Other Health Extenders) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Note: PREP= Personal Responsibility Education Program.

Table 6. Title VI (Child and Family Services and Supports Extenders): Description and CRS Contact Information, by Section

Section Number	Section Title	Description of Section	Contact
50601	Continuing Evidence-Based Home Visiting Program	Section 50601 provides for mandatory funding of $400 million for the MIECHV program for each of FY2017 through FY2022.	Adrienne Fernandes-Alcantara 7-9005 afernandes@crs.loc.gov
50602	Continuing to Demonstrate Results to Help Families	Section 50602 requires eligible entities to continue to track and report on at least four benchmark areas to demonstrate that the program results in improvements for participating families. The information must be reported within 30 days after the end of FY2020 and every three subsequent years. If improvements are not made within each three-year period, an eligible entity is required to develop and implement a plan to make improvements in each of the applicable benchmark areas. The HHS Secretary must terminate funding for the eligible entity if improvements are not made, or if the Secretary determines that the entity has failed to submit a required report on performance in the benchmark areas.	Adrienne Fernandes-Alcantara 7-9005 afernandes@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
50603	Reviewing Statewide Needs to Target Resources	Section 50603 requires eligible entities to conduct a statewide needs assessment by October 1, 2020, as a condition of receiving funds under the Maternal and Child Health Services Block Grant. The assessment must be coordinated with the statewide needs assessment required under the Maternal and Child Health Services Block Grant and may be conducted separately.	Adrienne Fernandes-Alcantara 7-9005 afernandes@crs.loc.gov
50604	Improving the Likelihood of Success in High-Risk Communities	Section 50604 continues to give priority for services to those high-risk families identified in the needs assessment, while also allowing eligible entities to take into account additional factors—staffing, community resource, and other requirements of the service-delivery model(s)—that are necessary for the model to operate and demonstrate improvements for these eligible families.	Adrienne Fernandes-Alcantara 7-9005 afernandes@crs.loc.gov
50605	Option to Fund Evidence-Based Home Visiting on a Pay-For-Outcome Basis	Section 50605 adds new language to enable an eligible entity to use up to 25% of its MIECHV grants for a pay-for-outcomes initiative that satisfies the requirements for providing evidence-based home visiting services. Funding for pay-for-outcomes initiatives may be expended by the eligible entity for up to 10 years after the funds are made available.	Adrienne Fernandes-Alcantara 7-9005 afernandes@crs.loc.gov
50606	Data Exchange Standards for Improved Interoperability	Section 50605 requires HHS to designate data exchange standards for necessary categories of information that a state agency operating a home visiting program is required to exchange with another state agency under federal law. In addition, HHS must designate data exchange standards to govern federal reporting and data exchanges required under federal law.	Adrienne Fernandes-Alcantara 7-9005 afernandes@crs.loc.gov
50607	Allocation of Funds	Section 50607 directs the HHS Secretary to use the most accurate federal population and poverty data available for each eligible entity if funds are awarded using these data.	Adrienne Fernandes-Alcantara 7-9005 afernandes@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
50611	Extension of Health Workforce Demonstration Projects for Low-Income Individuals	Section 50611 appropriates $85 million in mandatory funding for each of FY2018 and FY2019 for the Health Professions Opportunity Grants. These grants are used to assist low-income individuals—including individuals receiving assistance from the State Temporary Assistance for Needy Families program—to obtain education and training in health care jobs that pay well and are in high demand. Funds also are used to provide financial aid and other supportive services.	Elayne Heisler 7-4453 eheisler@crs.loc.gov

Source: CRS analysis of Title VI (Child and Family Services and Supports Extenders) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Notes: HHS = Department of Health and Human Services; MIECHV = Maternal, Infant, and Early Childhood Home Visiting.

Table 7. Title VII (Family First Prevention Services Act): Description and CRS Contact Information, by Section

(for more information on any of the provisions included in Title VII, please contact Emilie Stoltzfus at 7-2324 or estoltzfus@crs.loc.gov)

Section Number	Section Title	Description of Section
50701	Short Title	The short title of Division E, Title VII is expected to be the Family First Prevention Services Act (FFPSA).[a]
50702	Purpose	The purpose of this subtitle is to enhance support provided to states under SSA Title IV-B and IV-E for services to prevent placement of children in foster care and for kinship navigators.[b]
50711	Foster Care Prevention Services and Programs	Section 50711 amends the federal foster care program (included in SSA Title IV-E) to authorize the use of mandatory IV-E funds for (1) in-home parent skills-based programs and (2) substance abuse and mental health treatment services. Federal support for these services and programs will be available (beginning with FY2020) for up to 12 months for any child a state determines is at "imminent risk" of entering foster care (no income test) and to the child's parents or kin caregivers, so long as the service would enable that child to remain safely in the parent's home or with a kin caregiver. As of FY2020, any state (including DC) and any eligible tribe or territory electing to carry out these prevention activities under its Title IV-E program will be entitled to receive federal funding equal to at least 50% of the activities' cost, provided the services and programs meet certain evidence-based standards and the spending was above the jurisdiction's "maintenance of effort" level.

Section Number	Section Title	Description of Section
50712	Foster Care Maintenance Payments for Children with Parents in a Licensed Residential Family-Based Treatment Facility for Substance Abuse	Section 50712 permits federal Title IV-E foster care support to be paid for up to 12 months on behalf of a child in foster care who is placed with his/her parents in a licensed residential family-based substance abuse treatment facility. No income test would apply, but the placement must be recommended in the child's case plan. Further, the treatment facility must incorporate trauma-informed parent education, parenting skills training, and counseling as part of its substance abuse treatment program.
50713	Title IV-E Payments for Evidence-Based Kinship Navigator Programs	Any state (including DC), territory, or tribe with an approved Title IV-E plan may claim federal support for 50% of its cost of providing kinship navigator programs to help kin caregivers identify and access services and supports they need for themselves and the children in their care. No income test would apply to individuals served by this program. However, the navigator program must meet certain evidence-based standards to be Title IV-E-supported.
50721	Elimination of Time Limit for Family Reunification Services While in Foster Care and Permitting Time-Limited Family Reunification Services When a Child Returns Home from Foster Care	States, territories, and tribes must use some of the formula funding they receive under the Title IV-B PSSF program for specific child and family services. The section renames one of these categories as "family reunification services" and redefines these services to include services needed to reunite a child with his/her parents or caregivers without regard to the amount of time the child has been in care. Additionally, the section defines these services to include post-reunification services provided within the first 15 months after the child is reunited with his/her parents.
50722	Reducing Bureaucracy and Unnecessary Delays When Placing Children in Homes Across State Lines	As of FY2028, the section requires states with an approved Title IV-E plan, including DC (but not any of the territories or tribes), to incorporate use of an electronic interstate case processing system into their procedures for timely placing of foster children across state lines. The section requires HHS to reserve $5 million in FY2018 discretionary funding for the PSSF program to make grants to states (across any of FY2018-FY2022) intended to facilitate take-up and use of the electronic case processing system.
50723	Enhancements to Grants to Improve Well-Being of Families Affected by Substance Abuse	Section 50723 requires HHS to use $20 million in mandatory PSSF funding in each of FY2017-FY2021 to continue support for grants to collaborating public and private agencies (known as *regional partnerships*) to improve outcomes for children affected by parental substance abuse. In addition to required involvement of state child welfare, the section newly requires the state agency that administers federal substance abuse prevention and treatment funding, along with court(s) handling child abuse and neglect proceedings, to be involved in most funded regional partnerships. Among other changes, the section focuses new attention on use of these regional partnership grant funds to facilitate parents' recovery and expand the use of effective evidence-based practices.
50731	Reviewing and Improving Licensing Standards for Placement in a Relative Foster Home	As of October 1, 2018, HHS must identify model foster family home licensing standards. No later than April 1, 2019, each state, territory, or tribe operating a Title IV-E foster care program must report to HHS on whether its foster family home licensing standards are consistent with those identified by HHS. Additionally, this report must discuss the jurisdiction's use (or not) of its authority to waive nonsafety licensing standards for relative foster family homes.

Section Number	Section Title	Description of Section
50732	Development of a Statewide Plan to Prevent Child Abuse and Neglect Fatalities	Section 50732 requires a state under its plan for the Title IV-B CWS program to describe how it is developing and implementing a comprehensive statewide plan to prevent child maltreatment. The plan must involve other relevant public agencies and private partners (e.g., public health, law enforcement, and the courts).
50733	Modernizing the Title and Purpose of Title IV-E	Section 50733 changes the Title IV-E heading in the Social Security Act to "Federal Payments for Foster Care, Prevention, and Permanency" to better reflect the varieties of "permanency" support provided under current law and to reflect new support authorized for prevention services as part of this law. The section makes similar technical and conforming changes to the statement of purposes for which Title IV-E funds are provided.
50734	Effective Date	The general effective date for Sections 50711-50733 is the first day of FY2019 (October 1, 2018), except that the requirements regarding reviewing licensing standards (Section 50731) and the changes to the Title IV-E heading and purposes (Section 50733) were effective as of February 9, 2018 (date of enactment). Further, an annual $1 million mandatory appropriation to HHS to support technical assistance work related to Title IV-E prevention activities is available beginning with FY2018. Under certain circumstances, states, territories, and tribes may have limited additional time to meet any Title IV-B or Title IV-E state plan requirements added in Section 50711 through Section 50733.
50741	Limitation on Federal Financial Participation for Placements That Are Not in Foster Family Homes	For children who meet federal Title IV-E eligibility criteria and whose foster care placement setting is not with a foster family, the section will limit federal IV-E support for "maintenance" (room and board) payments under the program to 14 days, unless the child is placed in one of five specified nonfamily settings (including a QRTP). In addition to other requirements, a QRTP must have a treatment model that is able to meet the child's clinical, behavioral, or other needs. Among other changes, the section defines a foster family home, in part, as one where six or fewer children in foster care live with an individual who is their licensed foster care provider.
50742	Assessment and Documentation of the Need for Placement in Qualified Residential Treatment Programs	For any child placed in a QRTP, the section would require the state, territorial, or tribal child welfare agency operating a Title IV-E program to have additional case review procedures that (1) provide for a "qualified individual" to assess the child's placement in the QRTP within 30 days of the placement and for court review within 60 days of the placement; (2) ensure the child has a family and permanency team; (3) ensure regular and ongoing review of whether the QRTP is the most appropriate placement setting for the child; and (4) include additional oversight and review measures for children with longer stays in a QRTP.

Section Number	Section Title	Description of Section
50743	Protocols to Prevent Inappropriate Diagnoses	States (including DC), territories, and tribes operating a Title IV-E program must have a health oversight plan that provides specific physical, dental, and mental health care protocols for children in foster care. The section requires this health oversight plan to include procedures to ensure children are not placed in nonfoster family settings based on inappropriate diagnoses of mental illness, behavioral disorders, medical care needs, or developmental disabilities. HHS must study state compliance with this requirement, including effectiveness of protocols, and report to Congress on its findings.
50744	Additional Data and Reports Regarding Children Placed in a Setting That Is Not a Foster Family Home	Section 50744 revises certain child characteristic and outcome data that HHS must annually provide to Congress (as part of the Child Welfare Outcomes report). The section requires additional detail concerning the types of nonfoster family home settings in which children in foster care are placed, as well as more demographic details on children placed in those settings and on the timing, number, and range of their placement settings.
50745	Criminal Records Checks and Checks of Child Abuse and Neglect Registries for Adults Working in Child-Care Institutions and Other Group Care Settings	Section 50745 requires states (including DC), territories, and tribes operating a Title IV-E program to have provisions to conduct criminal history and child abuse and neglect registry checks on any adult working in a group setting who provides care to Title IV-E-eligible children in foster care. Generally, these checks must follow the procedures that have been in law for more than a decade with regard to prospective foster and adoptive parents (e.g., must be based on a fingerprint check of national crime information databases). However, in some instances a state may use an alternative method.
50746	Effective Dates; Application to Waivers	The provisions described above that place new limits on federal Title IV-E support for children placed in nonfoster family home settings (Sections 50741 and 50742) are generally effective with FY2020. However, a state, territory, or tribe may elect to delay that effective date by up to two years (and, if it does so, must delay receipt of any Title IV-E prevention services). Additionally, the requirements related to criminal background checks are effective with FY2019 (October 1, 2018). Other requirements, including those related to protocols to prevent inappropriate diagnoses and the revised reporting requirements for HHS, are effective as if enacted on January 1, 2018. Under certain circumstances, states, territories, and tribes may have limited additional time to meet any new Title IV-B or Title IV-E state plan requirements.
50751	Supporting and Retaining Foster Families for Children	Section 50751 revises the definition of "family support services" included in the Title IV-B PSSF program to explicitly include services designed to support and retain families providing quality family-based foster care. The section separately appropriates $8 million in mandatory funding for FY2018 (available through FY2022) for HHS to make competitive grants related to recruitment and retention of such foster families.

Section Number	Section Title	Description of Section
50752	Extension of Child and Family Services Programs	Section 50752 extends annual mandatory and discretionary authorizations of appropriations for the Title IV-B child and family services programs, CWS, and PSSF programs through FY2021. The section continues reservation of mandatory PSSF funds for monthly caseworker grants and regional partnership grants in each of those same years. The section extends annual state court entitlement to Court Improvement Program funding (reserved out of PSSF) through FY2021.
50753	Improvements to the John H. Chafee Foster Care Independence Program and Related Provisions	Section 50753 renames this program as the John H. Chafee Foster Care Program for Successful Transition to Adulthood and rewrites some of the program's purposes to focus on serving any youth who experiences foster care at aged 14 or older (as opposed to those expected to "age out"). For those who age out of foster care, the section permits Chafee program services to continue up to age 23, in states that extend federal foster care assistance up to age 21. The section permits youth who age out of care to retain eligibility for Education and Training Vouchers up to age 26. The section amends the Title IV-E program to require states to provide youth aging out of foster care with official documentation to prove they were previously in foster care.
50761	Reauthorizing Adoption and Legal Guardianship Incentive Programs	Section 50761 extends the authorization of discretionary appropriations for adoption and legal guardianship incentive payments through FY2021. The section maintains the prior-law incentive structure, which provides payments to states that increase the rate at which children appropriately leave foster care for new permanent homes via adoption or legal guardianship.
50771	Technical Corrections to Data Exchange Standards to Improve Program Coordination	Section 50771 rewrites the current law provisions to require that data exchange standards to be established in regulation address the categories of information that state child welfare agencies must be able to exchange with other state agencies, as well as the federal reporting and data exchange requirements for child welfare programs included in SSA Titles IV-B and IV-E. The regulations are to be proposed no later than 24 months after enactment (i.e., February 9, 2020).
50772	Technical Corrections to State Requirement to Address the Developmental Needs of Young Children	Section 50772 clarifies that each state must describe in its Title IV-B plan for the CWS program what it is doing to address the developmental needs of *all* vulnerable children under 5 years of age who are served by the agency (under either the CWS or PSSF program)—not just those young children who are in foster care.
50781	Delay of Adoption Assistance Phase-In	As of October 1, 2017, no child, regardless of age at the time of his or her adoption, was required to meet an income-eligibility test for purposes of determining eligibility for Title IV-E adoption assistance. Section 50781 provides that, for certain children who are adopted before their second birthday, the prior-law income test (which is applied to the home the child was removed from, not the adoptive home) is temporarily reinstated for six and a half years (January 1, 2018- June 30, 2024). This provision does not affect eligibility for Title IV-E adoption assistance of any child whose eligibility was determined before January 1, 2018.

Section Number	Section Title	Description of Section
50782	GAO Study and Report on State Reinvestment of Savings Resulting from Increase in Adoption Assistance	When Congress initially began to phase in new Title IV-E adoption assistance eligibility rules to remove the income test for purposes of determining Title IV-E adoption assistance eligibility, it required states to reinvest any savings in state (or nonfederal) dollars that resulted from this expansion in federal adoption assistance eligibility. Section 50782 requires GAO to report to Congress on whether states are complying with this requirement.

Source: CRS analysis of Title VII (Family First Prevention Services Act) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Notes: For a more detailed description of each of these provisions, request a copy of CRS Congressional Distribution Memorandum, "Family First Prevention Services Act (Family First): Final Enacted Provisions Compared to Earlier House-Approved Language and Prior Law," by Emilie Stoltzfus. CWS = Stephanie Tubbs Jones Child Welfare Services; DC = District of Columbia; FFPSA = Family First Prevention Services Act; GAO = Government Accountability Office; HHS = Department of Health and Human Services; PSSF = Promoting Safe and Stable Families Program; QRTP = Qualified residential treatment program; SSA = Social Security Act.

a. As enacted, the short title of these Title VII provision is given as the "Bipartisan Budget Act of 2018." However, this is an unintentional error.

b. Title VII as enacted includes only one subtitle heading (Subtitle A), which appears near the beginning of the title. The title, however, is divided into multiple parts (Parts I-VIII). In FFPSA legislation introduced as a stand-alone measure (H.R. 253), these purposes were proposed as applying to the provisions now included in Parts I-III of Title VII, Division E, H.R. 1892.

Table 8. Title VIII (Supporting Social Impact Partnerships to Pay for Results): Description and CRS Contact Information, by Section

(for more information on any of the provisions included in Title VIII, please contact Clinton Brass at 7-4536 or cbrass@crs.loc.gov or Natalie Keegan at 7-9569 or nkeegan@crs.loc.gov)

Section Number	Section Title	Description of Section
50801	Short Title	The short title of Division E, Title VIII is the Social Impact Partnerships to Pay for Results Act.
50802	Social Impact Partnerships to Pay for Results	Section 50802 establishes in SSA Title XX a framework for demonstration projects called SIPs—sometimes also referred to as *social impact bonds*—which finance social services through a complex network of contract-like arrangements and with an emphasis on certain evaluation methodologies. With a $100 million mandatory appropriation, the act authorizes the Secretary of the Treasury to enter into SIP "agreements" under the act's "SIP model" with state or local governments, which in turn coordinate with service providers, investors, evaluators, and intermediaries to conduct projects in pursuit of one or more social policy outcomes. Under this form of grant making, the federal government would make a payment to a state or local government if a project (1) meets the requirements of the agreement and (2) achieves one or more specified policy outcomes, as validated by an independent evaluation.

Source: CRS analysis of Title VIII (Supporting Social Impact Partnerships to Pay for Results) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Notes: SIP = Social impact partnership; SSA = Social Security Act.

Table 9. Title IX (Public Health Programs): Description and CRS Contact Information, by Section

(for more information on any of the provisions included in Title IX, please contact Elayne Heisler at 7-4453 or eheisler@crs.loc.gov)

Section Number	Section Title	Description of Section
50901(a and b)	Extension for Community Health Centers	Section 50901(a) appropriates $3.8 billion for FY2018 and $4.0 billion for FY2019 in mandatory funds to the Community Health Center Fund, which supports health centers that provide health services to individuals in health professional shortage areas without regard for their ability to pay. Section 50901(b) makes a number of changes to the grants awarded to support these centers and provided $25 million for FY2018 for health centers to participate in the Precision Medicine Initiative's All of Us research program.
50901(c)	Extension for the National Health Service Corps	Section 50901(c) appropriates $310 million for each of FY2018 and FY2019 in mandatory funds to support the National Health Service Corps, which provides scholarship and loan repayment to health professionals in exchange for providing care in health professional shortage areas for a minimum of two years.
50901(d)	Extension for Teaching Health Centers That Operate Graduate Medical Education Programs	Section 50901(d) appropriates $126.5 million for each of FY2018 and FY2019 in mandatory funds to support graduate medical education (i.e., medical residency training) at teaching health centers, which are outpatient centers located in shortage areas. It also makes a number of changes to the program to permit payments to be made to expanding existing programs and newly established programs and to add additional reporting requirements. This new funding level is more than double what the program received for FY2017.
50901(e)	Funding Restrictions	Section 50901(e) applies existing restrictions on the use of funds for abortions (included in the Consolidated Appropriations Act, 2017 [P.L. 115-31]) to funds appropriated by this act to health centers, the National Health Service Corps, and qualified teaching health centers for FY2018 and FY2019.
50901(f)	Health Services for Victims of Human Trafficking	Section 50901(f) permits HHS to continue to transfer to the Department of Justice between $5 million and $30 million of funds appropriated to the Community Health Center Fund to be used for health services for victims of human trafficking.
50902	Extension of Special Diabetes Programs	Section 50902 appropriates $150 million in mandatory funds for each of FY2018 and FY2019 for the Special Diabetes Program for Type 1 Diabetes, which provides funding for the National Institutes of Health to award grants for research into the prevention and cure of Type 1 diabetes. It also provides an additional $150 million for each of FY2018 and FY2019 for 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.

Source: CRS analysis of Title IX (Public Health Programs) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Notes: IHS= Indian Health Service; HHS=Department of Health and Human Services.

Table 10. Title X (Miscellaneous Health Care Policies): Description and CRS Contact Information, by Section

Section Number	Section Title	Description of Section	Contact
51001	Home Health Payment Reform	Section 51001 instructs the HHS Secretary to modify the prospective payment system under Medicare for home health services beginning in 2020. The payment system must apply a 30-day episode for payment, and the new system must be budget neutral, among other requirements. The section also requires HHS and MedPAC reports related to the new payment system.	Phoenix Voorhies 7-9955 pvoorhies@crs.loc.gov
51002	Information to Satisfy Documentation of Medicare Eligibility for Home Health Services	Section 51002 expands the scope of materials that can be used by the HHS Secretary to satisfy Medicare eligibility for home health services furnished by a home health agency beginning January 1, 2019.	Phoenix Voorhies 7-9955 pvoorhies@crs.loc.gov
51003	Technical Amendments to Public Law 114-10	Section 51003 makes technical modifications to the changes in Medicare physician payment as directed by MACRA. The phrase "covered professional services" replaces existing references to "items and services," and the period for development, weighting, and transitioning to the resource use component of the merit incentive-based payment system is increased from two to five years. Additionally, the provision extends and clarifies the responsibilities of the Physician-Focused Payment Model Technical Advisory Committee with regard to review and feedback of proposed models.	Jim Hahn 7-4914 jhahn@crs.loc.gov
51004	Expanded Access to Medicare Intensive Cardiac Rehabilitation Programs	Section 51004 adds two additional conditions under which providers can qualify to become an ICR program under Medicare. Coverage for CR and ICR services was established by the Medicare Improvements for Patients and Providers Act of 2008 and includes physician-prescribed exercise, cardiac-risk-factor modification, psychosocial assessment, outcomes assessment, and an individualized treatment plan. ICR services are physician-supervised programs that furnish the same items and services under the same conditions as a cardiac rehabilitation program but also have been demonstrated through peer-reviewed published research to improve patients' cardiovascular disease through specific outcome measurements.	Jim Hahn 7-4914 jhahn@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
51005	Extension of Blended Site-Neutral Payment Rate for Certain Long-Term-Care Hospital Discharges; Temporary Adjustment to Site Neutral Payment Rates	Section 51005 extends the transition period to site-neutral Medicare payments for certain long-term care hospital services for an additional two years, FY2018 and FY2019. The cost of the extended phase-in period is offset by reducing the applicable Inpatient Prospective Payment System-comparable per diem amount by 4.6% for FY2018 through FY2026.	Marco Villagrana 7-3509 mvillagrana@crs.loc.gov
51006	Recognition of Attending Physician Assistants as Attending Physicians to Serve Hospice Patients	Section 51006 allows physician assistants to serve as attending physicians for hospice care, starting January 1, 2019.	Phoenix Voorhies 7-9955 pvoorhies@crs.loc.gov
51007	Extension of Enforcement Instruction on Supervision Requirements for Outpatient Therapeutic Services in Critical Access and Small Rural Hospitals Through 2017	Section 51007 extends the critical access hospital and small rural hospital moratorium on the requirement that outpatient therapeutic services furnished in hospital outpatient departments be required to have direct physician supervision for one year through the end of CY2017.	Jim Hahn 7-4914 jhahn@crs.loc.gov
51008	Allowing Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists to Supervise Cardiac, Intensive Cardiac, and Pulmonary Rehabilitation Programs	Section 51008 adds physician assistants, nurse practitioners, and clinical nurse specialists to the list of providers who are permitted to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs beginning January 1, 2024. Prior to this date, supervision by a physician is required under Medicare statute.	Jim Hahn 7-4914 jhahn@crs.loc.gov
51009	Transitional Payment Rules for Certain Radiation Therapy Services Under the Physician Fee Schedule	Section 51009 extends by one year, through 2019, the codes and payment rules for certain radiation therapy services. These services were previously identified as having misvalued codes and payment; the Patient Access and Medicare Protection Act (P.L. 114-115) set payments for 2017 and 2018 at the 2016 level while requiring CMS to develop an episodic payment model to replace the existing codes and payment.	Jim Hahn 7-4914 jhahn@crs.loc.gov

Source: CRS analysis of Title X (Miscellaneous Health Care Policies) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Notes: CR = Cardiac Rehabilitation; CMS = Centers for Medicare & Medicaid Services; HHS = Department of Health and Human Services; ICR = Intensive cardiac rehabilitation; MACRA = Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10); MedPAC = Medicare Payment Advisory Commission.

Table 11. Title XI (Protecting Seniors' Access to Medicare Act): Description and CRS Contact Information, by Section

Section Number	Section Title	Description of Section	Contact
52001	Repeal of the Independent Payment Advisory Board	The IPAB, established as part of the ACA, was charged with developing proposals to "reduce the per capita rate of growth in Medicare spending." The board was to be composed of 15 members appointed by the President with the advice and consent of the Senate but was never constituted, in part because the conditions that would have triggered IPAB activity were never met. Section 52001 repeals the IPAB.	Jim Hahn 7-4914 jhahn@crs.loc.gov

Source: CRS analysis of Title XI (Protecting Seniors' Access to Medicare Act) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); IPAB = Independent Payment Advisory Board.

Table 12. Title XII (Offsets): Description and CRS Contact Information, by Section

Section Number	Section Title	Description of Section	Contact
53101	Modifying Reductions in Medicaid DSH Allotments	Section 53101 amends the Medicaid DSH reductions by eliminating the reductions for FY2018 and FY2019 and increasing the annual reduction amounts for FY2021 through FY2023.	Alison Mitchell 7-0152 amitchell@crs.loc.gov
53102	Third-Party Liability in Medicaid and CHIP	Section 53102 makes various amendments to third-party liability rules in Medicaid and CHIP. Among other changes, it narrows the scope of a provision in prior law that protected providers of prenatal and preventive pediatric services from the obligation to seek out payments from liable third parties, so that the provision no longer applies to prenatal services, effective on the date of enactment. It also retrospectively repeals a provision in prior law, making it as if the provision were never enacted; that repealed provision had enabled states to recover all portions of judgments and liability settlements received by Medicaid enrollees as sources of payment primary to Medicaid. GAO is required to report to Congress on the impacts of the changes in this section.	Susannah Gopalan 7-3351 sgopalan@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
53103	Treatment of Lottery Winnings and Other Lump-Sum Income for Purposes of Income Eligibility Under Medicaid	Section 53103 requires states to consider qualified lottery winnings and/or qualified lump-sum income received by an individual on or after January 1, 2018, when determining eligibility for Medicaid based on modified adjusted gross income for each such individual.	Evelyne Baumrucker 7-8913 ebaumrucker@crs.loc.gov
53104	Rebate Obligation with Respect to Line Extension Drugs	Section 53104 clarifies how the Medicaid rebate is calculated for certain innovator single- or multiple-source covered drugs that are line extensions of existing drugs, such as extended-release formulations. Under Section 53104, the Medicaid rebate for covered innovator single- and multiple-source line-extension drugs is the greater of (1) the total rebate for the reference product or (2) the total rebate for the line-extension product, for rebate periods beginning on or after October 1, 2018.	Cliff Binder 7-7965 cbinder@crs.loc.gov
53105	Medicaid Improvement Fund	Section 53105 rescinds $5 million in appropriations in the Medicaid Improvement Fund for expenditures beginning in FY2021 and thereafter to improve CMS Medicaid program management, including contract and contractor oversight and demonstration evaluation. In addition, Section 53105 rescinds $980 million in appropriations in the Medicaid Improvement Fund for expenditures beginning in FY2023 and thereafter that relate to state activities for mechanized claims systems. Funds in the Medicaid Improvement Fund may be obligated ahead of their first fiscal year of availability, but only if the amount to be obligated does not exceed the amount available to the fund.	Cliff Binder 7-7965 cbinder@crs.loc.gov
53106	Physician Fee Schedule Update	MACRA establishes annual updates to the payments under the Medicare physician fee schedule of 0.5% for the years CY2016 through CY2019. This provision modifies the update for CY2019 to be 0.25%.	Jim Hahn 7-4914 jhahn@crs.loc.gov
53107	Payment for Outpatient Physical Therapy Services and Outpatient Occupational Therapy Services Furnished by a Therapy Assistant	Section 53107 authorizes Medicare payment for outpatient physical and occupational therapy services provided by therapy assistants beginning January 1, 2022; the payment rate for services provided by therapy assistants is to be 85% of what the payment otherwise would have been. The HHS Secretary is to define the term *therapy assistant*.	Jim Hahn 7-4914 jhahn@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
53108	Reduction for Non-Emergency ESRD Ambulance Transports	Section 53108 modifies the Medicare ambulance fee schedule to reduce payments by 23% for non-emergency, basic life support transport services to and from dialysis for Medicare beneficiaries with ESRD beginning October 1, 2018.	Marco Villagrana 7-3509 mvillagrana@crs.loc.gov
53109	Hospital Transfer Policy for Early Discharges to Hospice Care	Section 53109 amends the Medicare hospital transfer policy to apply to transfers from a hospital to a hospice program beginning with hospital discharges on or after October 1, 2018, and directs MedPAC to assess the effect of this change.	Marco Villagrana 7-3509 mvillagrana@crs.loc.gov
53110	Medicare Payment Update for Home Health Services	Section 53110 increases Medicare reimbursement for home health agency providers by 1.5% in CY2020.	Phoenix Voorhies 7-9955 pvoorhies@crs.loc.gov
53111	Medicare Payment Update for Skilled Nursing Facilities	Section 53111 increases Medicare reimbursement for skilled nursing facility providers by 2.4% in FY2019.	Phoenix Voorhies 7-9955 pvoorhies@crs.loc.gov
53112	Preventing the Artificial Inflation of Star Ratings After the Consolidation of Medicare Advantage Plans Offered by the Same Organization	Section 53112 requires the HHS Secretary to assign an enrollee-weighted average quality score in the event an MA organization consolidates plans starting January 1, 2019. Previously, the quality score assigned in the merger of two plans would be based on the remaining plan, regardless of the quality of the plan that had been subsumed.	Paulette Morgan 7-7317 pcmorgan@crs.loc.gov
53113	Sunsetting Exclusions of Biosimilars from Medicare Part D Coverage Gap Discount Program	Section 53113 applies the Medicare Part D mandatory manufacturer discount on brand-name drugs purchased in the coverage gap, or "donut hole," to biosimilar products, beginning in CY2019.	Suzanne Kirchhoff 7-0658 skirchhoff@crs.loc.gov
53114	Adjustments to Medicare Part B and Part D Premium Subsidies for Higher-Income Individuals	Section 53114 requires that Medicare beneficiaries with annual incomes of $500,000 or more, and couples with incomes of $750,000 or more, pay premiums for Parts B and D that cover 85% of the average annual per capita costs of these benefits beginning in 2019 (instead of 80%, as under prior law). The income threshold at this top level will be frozen through 2027 and adjusted annually for inflation starting in 2028.	Patricia Davis 7-7362 pdavis@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
53115	Medicare Improvement Fund	The Medicare Improvement Fund was established to provide the HHS Secretary with mandatory appropriations with which to make improvements under the original Medicare fee-for-service program under Parts A and B. To date, no funds have been used for the purposes as described; however, the amounts in the fund have been modified many times since establishment. Section 53115 rescinds $220 million in the fund, reducing it to $0.	Jim Hahn 7-4914 jhahn@crs.loc.gov
53116	Closing the Donut Hole for Seniors	Section 53116 closes the Medicare Part D coverage gap, or "donut hole," for brand-name drugs one year early, in CY2019. It also requires manufacturers to provide a 70% price discount on brand-name drugs that enrollees purchase in the donut hole, an increase from the current 50% requirement, starting in CY2019.	Suzanne Kirchhoff 7-0658 skirchhoff@crs.loc.gov
53117	Modernizing Child Support Enforcement Fees	The CSE program (SSA Title IV-D) provides services to families that receive cash and other kinds of public assistance and may also serve families not receiving any assistance. Nonassistance families must pay certain fees, including an annual user fee, when the CSE agency collects a certain level of child support payments on behalf of the family in a given fiscal year (unless the state opts to pay the federal portion of the fee out of state funds). Effective October 1, 2018, Section 53117 mandates that the annual user fee be increased by $10 (to $35) and the minimum amount of child support collected in order for the fee to be assessed be increased by $50 (to $550).	Jessica Tollestrup 7-0941 jtollestrup@crs.loc.gov
53118	Increasing Efficiency of Prison Data Reporting	Under the Social Security Administration's Prisoner Incentive Payment Program, state or local correctional facilities may receive incentive payments from the Social Security Administration for reporting information to the agency on the confinement of individuals who receive SSI payments. The confinement must be reported within a specified number of days, and the amount of the incentive payment varies by the number of days from confinement to report. Section 53118 makes the $400 incentive payment available to correctional facilities only if the report is made to the Social Security Administration within 15 days of the SSI recipient's confinement (instead of within 30 days).	William Morton 7-9453 wmorton@crs.loc.gov

Section Number	Section Title	Description of Section	Contact
53119	Prevention and Public Health Fund	Section 53119 repeals $1.35 billion in mandatory appropriations to the Prevention and Public Health Fund for FY2019 through FY2027. It redistributes funds over that period, with increased appropriations for FY2019 through FY2021 and decreased appropriations across the later fiscal years.	Sarah A. Lister 7-7320 slister@crs.loc.gov

Source: CRS analysis of Title XII (Offsets) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Division E of the Bipartisan Budget Act of 2018 (P.L. 115-123).

Notes: CHIP = State Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; CSE = Child Support Enforcement Program DSH = Disproportionate share hospital; ESRD = End-stage renal disease; GAO = Government Accountability Office; HHS = Department of Health and Human Services; MA = Medicare Advantage; MACRA = Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10); MedPAC = Medicare Payment Advisory Commission; SSA = Social Security Act; SSI = Supplemental Security Income.

Appendix. List of Abbreviations

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

ACCESS: Advancing Chronic Care, Extenders, and Social Services Act (P.L. 115-123)

ACO: Accountable Care Organization

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

CBO: Congressional Budget Office

CHIP: State Children's Health Insurance Program

CMMI: Center for Medicare & Medicaid Innovation

CMS: Centers for Medicare & Medicaid Services

CR: Cardiac Rehabilitation

CRS: Congressional Research Service

CSE: Child Support Enforcement

CWS: Stephanie Tubbs Jones Child Welfare Services

DSH: Disproportionate Share Hospital

EHR: Electronic Health Record

ESRD: End-Stage Renal Disease

FFPSA: Family First Prevention Services Act

GAO: Government Accountability Office

GPCI: Geographic Practice Cost Index

HHS: Department of Health and Human Services

ICR: Intensive Cardiac Rehabilitation

IHS: Indian Health Service

IPAB: Independent Payment Advisory Board

LVH: Low-Volume Hospital

MA: Medicare Advantage

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

MDH: Medicare-Dependent Hospital

MedPAC: Medicare Payment Advisory Commission

MIECHV: Maternal, Infant, and Early Childhood Home Visiting

MSSP: Medicare Shared Savings Program

NQF: National Quality Forum

PREP: Personal Responsibility Education Program

PSSF: Promoting Safe and Stable Families

QRTP: Qualified Residential Treatment Program

SIP: Social Impact Partnership

SHIP: State Health Insurance Assistant Program

SNP: Special Needs Plans

SSA: Social Security Act

SSI: Supplemental Security Income

VBID: Value-Based Insurance Design

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