

Bipartisan Budget Act of 2018 (P.L. 115-123): CHIP, Public Health, Home Visiting, and Medicaid Provisions in Division E

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Summary

The Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123), which was enacted on February 9, 2018, addresses a number of issues that were before Congress. For example, appropriations for most federal agencies and programs were to expire on February 8, 2018, and BBA 2018 extends continuing appropriations for these agencies and programs through March 23, 2018. In addition, BBA 2018 includes 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.

Division E of BBA 2018 is titled the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, which includes provisions affecting the following programs:

- Medicare;
- Medicaid;
- the State Children’s Health Insurance Program (CHIP);
- public health programs;
- the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program;
- foster care and child welfare;
- social impact partnerships;
- child support enforcement;
- and prison data reporting.

This report provides information about the provisions from Division E of BBA 2018 related to CHIP, certain public health programs, the MIECHV program, and the Medicaid program.

BBA 2018 extends CHIP funding and other CHIP-related provisions (i.e., the Child Enrollment Contingency Fund, the qualifying states option, the Express Lane Eligibility option, the maintenance of effort [MOE] for children, the Pediatric Quality Measures Program, and the outreach and enrollment program) for FY2024 through FY2027.

BBA 2018 extends funding for a number of public health programs that were funded through direct appropriations. Among the programs that receive additional funding through BBA 2018 for FY2018 and FY2019 are two Special Diabetes Programs, funding for the Health Professions Opportunity Grant Program, and the National Health Service Corps. BBA 2018 also extends funding, and in some cases increased funding, with programmatic changes for the Family-to-Family Health Information Program, an abstinence education program now known as the Sexual Risk Avoidance Education program; the Personal Responsibility Education Program (which relates to teen pregnancy prevention); the health center program; and the teaching health center graduate medical education program. In addition, the law reduces the amounts appropriated to the Public Health and Prevention Fund as a funding offset.

BBA 2018 also extends funding of \$400 million annually for the MIECHV program from FY2017 through FY2022. It requires states and other jurisdictions to continue to track and report on performance outcomes. It also allows jurisdictions to use some MIECHV funding for a pay-for-outcomes initiative, among other changes.

BBA 2018 includes some Medicaid provisions as offsets. These Medicaid offsets are related to (1) Medicaid disproportionate share hospital (DSH) allotments; (2) the third-party liability (TPL) rules; (3) consideration of “qualified lottery winnings” and/or “qualified lump sum income” when

determining Medicaid eligibility; (4) the rebate obligation with respect to line-extension drugs; and (5) the Medicaid Improvement Fund.

This report provides a table with abbreviated summaries for the provisions in Division E of BBA 2018 related to CHIP, certain public health programs, the MIECHV program, and the Medicaid program. The table is followed by detailed summaries for each of these provisions, including background information and descriptions of the BBA 2018 provision.

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Introduction

The Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123), which was enacted on February 9, 2018, addresses a number of issues that were before Congress. Specifically, appropriations for most federal agencies and programs were set to expire on February 8, 2018, and BBA 2018 extends continuing appropriations for these agencies and programs through March 23, 2018. In addition, BBA 2018 includes 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.

Division E of BBA 2018 is titled the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, which includes provisions affecting the following programs: Medicare; Medicaid; the State Children’s Health Insurance Program (CHIP); public health programs; the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program; foster care and child welfare; social impact partnerships; child support enforcement; and prison data reporting.¹

This report provides information about the provisions from Division E of BBA 2018 related to CHIP, certain public health programs, the MIECHV program, and the Medicaid program. It covers Division E provisions related to four topics:

- CHIP (§§50101-50103).
- Public Health Extenders (§§50501-50503, §50611, §50901, §50902, and §53119).
- MIECHV (§§50601-50607).
- Medicaid (§§53101-53105).

This report provides high-level summaries for each topic followed by a table with abbreviated summaries of each provision. The four sections following the table provide more detailed summaries of these provisions related to each topic.

High-Level Summary

Below is a high-level summary of the four sections of this report: CHIP, public health extenders, MIECHV, and Medicaid. The table following these summaries provides abbreviated summaries for each provision.

CHIP

CHIP is a means-tested program that provides health coverage to targeted low-income children and pregnant women. At the start of FY2018 (i.e., on October 1, 2017), there was no funding for FY2018 CHIP allotments to states. States were able to continue funding the federal share of their CHIP programs with unspent funds from FY2017 allotments and unspent allotments from FY2016 and prior years redistributed to shortfall states. In addition, continuing resolutions enacted on December 8, 2017 (P.L. 115-90), and December 22, 2017 (P.L. 115-96), included provisions that provided short-term funding for CHIP.

¹ For abbreviated summaries of all the provision in Division E of the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123), see CRS Report R45126, *Bipartisan Budget Act of 2018 (P.L. 115-123): Brief Summary of Division E—The Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act*. For an overview of the foster care and child welfare provisions, see CRS Insight IN10858, *Family First Prevention Services Act (FFPSA)*.

The continuing resolution enacted on January 22, 2018 (P.L. 115-120), provided federal CHIP funding for FY2018 through FY2023. P.L. 115-120 also extended other CHIP-related provisions through FY2023, among other things. These other CHIP-related provisions include the Child Enrollment Contingency Fund, the qualifying states option, the Express Lane Eligibility option, the maintenance of effort (MOE) for children, the Pediatric Quality Measures Program, and the outreach and enrollment program.

BBA 2018 further extends CHIP funding and these other CHIP-related provisions through FY2027. According to the Congressional Budget Office (CBO) cost estimate, the CHIP provisions in BBA 2018 are estimated to reduce federal spending by \$0.3 billion and increase revenues by \$4.6 billion, for a net savings of \$4.9 billion over the period of FY2018 through FY2027.²

Public Health³

BBA 2018 extends funding for a number of public health programs funded through mandatory appropriations. In some cases, funding for those programs had ended at the end of FY2017 (i.e., September 30, 2017), while in others, funding had been provided for one or more quarters of FY2018. Among the programs that receive additional funding through BBA 2018 for FY2018 and FY2019 are two Special Diabetes Programs, the Health Professions Opportunity Grant Program, and the National Health Service Corps. These programs are largely extended without programmatic changes.

BBA 2018 also extends or increases FY2018 and FY2019 mandatory funding for—and makes programmatic changes to—the Family-to-Family Health Information Program, an abstinence education program now known as the Sexual Risk Avoidance Education program; the Personal Responsibility Education Program (which relates to teen pregnancy prevention); the health center program; and the teaching health center graduate medical education program. In some cases, legislation had been introduced that would have extended funding for these programs, but no long-term funding extensions had been enacted prior to BBA 2018.

In addition to the funding extensions included in the BBA 2018, the law reduces the amounts appropriated to the Public Health and Prevention Fund as a funding offset.

According to the CBO cost estimate, the public health provisions in Division E of BBA 2018 are estimated to increase federal spending by a net of \$8.0 billion over the period of FY2018 through FY2027.⁴

Maternal, Infant, and Early Childhood Home Visiting Program

The MIECHV program provides grants to states, territories, and tribes (“eligible entities”) in support of evidence-based early childhood home visiting. Home visiting entails in-home visits by health or social service professionals with at-risk families. BBA 2018 extends mandatory funding of \$400 million for the program for each of FY2017 through FY2022. The law requires eligible entities to continue to track and report on program performance measures. Eligible entities must also conduct a new statewide needs assessment to determine which communities are most at risk

² Congressional Budget Office (CBO), 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>.

³ Division B of BBA 2018 includes a provision that provides additional health center funding for Puerto Rico and the U.S. Virgin Islands.

⁴ CBO 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>.

of poor child and family outcomes and to identify resources that can support those communities. Further, the law requires the U.S. Department of Health and Human Services (HHS) to designate data exchange standards to govern state and federal reporting on home visiting, and directs HHS to use the most accurate federal population and poverty data available for each eligible entity that is awarded funds. Under the BBA 2018, jurisdictions may use some MIECHV funding for a pay-for-outcomes initiative.

According to the CBO cost estimate, the MIECHV program provisions in BBA 2018 are estimated to increase federal spending by \$2.0 billion over the period of FY2018 through FY2027.⁵

Medicaid⁶

BBA 2018 includes some Medicaid provisions as offsets. These Medicaid offsets are (1) modifying the reductions to Medicaid disproportionate share hospital (DSH) allotments; (2) making various changes to the third-party liability (TPL) rules; (3) requiring states to consider “qualified lottery winnings” and/or “qualified lump sum income” when determining Medicaid eligibility for certain individuals; (4) changing the rebate obligation with respect to line-extension drugs; and (5) rescinding funds from the Medicaid Improvement Fund.

According to the CBO cost estimate, the Medicaid provisions in Division E of BBA 2018 are estimated to reduce federal spending by \$11.3 billion over the period of FY2018 through FY2027.⁷

Abbreviated Summary of Provisions

Table 1 provides a high-level summary of the provisions under Division E of BBA 2018 for CHIP, public health, the MIECHV program, and Medicaid. For each provision, the section of the law, the title of the provision, a summary of the provision, and a CRS contact are provided.

⁵ CBO, 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>.

⁶ Division B of BBA 2018 includes a provision that provides additional Medicaid funding to Puerto Rico and the U.S. Virgin Islands and increases the federal Medicaid matching rate to 100% for these additional funds.

⁷ CBO, 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 I. Abbreviated Summaries of Provisions

Section Number	Section Title	Description of Section	Contact
CHIP Provisions			
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
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
50101(d)	Extension of Qualifying States Option	Section 50101(d) extends the qualifying states option for the period of FY2024 through FY2027.	Alison Mitchell
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
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
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
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
Public Health Provisions			

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
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
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
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

Section Number	Section Title	Description of Section	Contact
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.	Elayne Heisler
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.	Elayne Heisler
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.	Elayne Heisler
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.	Elayne Heisler
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.	Elayne Heisler

Section Number	Section Title	Description of Section	Contact
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 I Diabetes, which provides funding for the National Institutes of Health to award grants for research into the prevention and cure of Type I 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.	Elayne Heisler
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
MIECHV Provisions			
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
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

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
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
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
50606	Data Exchange Standards for Improved Interoperability	Section 50606 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
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

Medicaid Provisions

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
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
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
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

Section Number	Section Title	Description of Section	Contact
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

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 (P.L. 115-123).

Notes: CHIP = State Children’s Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DSH = Disproportionate share hospital; GAO = Government Accountability Office; HHS = Department of Health and Human Services; IHS= Indian Health Service; MIECHV = Maternal, Infant, and Early Childhood Home Visiting; and PREP= Personal Responsibility Education Program.

Detailed Summaries of Provisions

This section provides more detailed summaries of the provisions under Division E of BBA 2018 for CHIP, public health, the MIECHV program, and Medicaid. For each provision, there is a background summary followed by an explanation of the provision in BBA 2018.

CHIP Provisions

Section 50101(a) and (b)(2): Funding Extension of CHIP Through FY2027

Background

Prior to the enactment of BBA 2018, CHIP was funded through FY2023 with appropriated amounts specified in statute.⁸ Since CHIP was first established in 1997 in the Balanced Budget Act of 1997 (BBA97, P.L. 105-33), it has been funded through subsequent legislation, including the following major laws:

- the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA; P.L. 111-3), which provided federal CHIP funding for FY2009 through FY2013;
- the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), which provided federal CHIP funding for FY2014 and FY2015;
- the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10), which provided funding for FY2016 and FY2017; and
- the continuing resolution enacted on January 22, 2018 (P.L. 115-120), which provided funding for FY2018 through FY2023.

The annual appropriation amounts for FY2018 through FY2022 increase annually from \$21.5 billion in FY2018 to \$25.9 billion in FY2022. The FY2023 appropriation is a combination of semiannual appropriations of \$2.85 billion from Section 2104(a) of the Social Security Act (SSA) and a one-time appropriation of \$20.2 billion from P.L. 115-120, which is provided for the first six months of the fiscal year and remains available until expended.

Provision

Sections 50101(a) and (b)(2) extend federal CHIP funding for an additional four years by adding federal appropriations for FY2024 through FY2027 under SSA Section 2104(a). The funding amounts for FY2024 through FY2026 are not specified; instead, the appropriation provides such sums as necessary to fund allotments to states.

The funding for FY2027 is structured as it is for FY2023, with semiannual appropriations of equal amounts plus a one-time appropriation. In FY2027, the semiannual appropriations are \$7.65 billion, and the one-time appropriation provides such sums as necessary to fund the allotments to states after taking into account the semiannual appropriations.

⁸ For more information about CHIP financing, see CRS Report R43949, *Federal Financing for the State Children’s Health Insurance Program (CHIP)*.

Section 50101(b)(1): Allotments

Background

The federal government reimburses states for a portion of every dollar they spend on CHIP, up to state-specific annual limits, called allotments. Allotments are the federal funds allocated to each state for the federal share of its CHIP expenditures. State CHIP allotment funds are provided annually, and the funds are available to states for two years. Recently, P.L. 115-120 extended the authorization for CHIP allotments through FY2023.

Two formulas are used to determine state allotments: an even-year formula and an odd-year formula. In even years, such as FY2018, state CHIP allotments are based on each state's federal *allotment* for the prior year. In odd years, state CHIP allotments are based on each state's *spending* for the prior year. In every year, the allotment amounts are adjusted for growth in per capita National Health Expenditures and child population in the state.⁹

Provision

Sections 50101(b)(1) authorizes CHIP allotments for FY2024 through FY2027 under SSA Section 2104(m), maintaining the allotment formulas for odd- and even-year allotments.

Section 50101(c): Extension of Child Enrollment Contingency Fund

Background

CHIPRA established the Child Enrollment Contingency Fund to provide shortfall funding to certain states. It was funded with an initial deposit equal to 20% of the appropriated amount for FY2009 (i.e., \$2.1 billion). In addition, for FY2010 through FY2023, such sums as are necessary for making Child Enrollment Contingency Fund payments to eligible states were to be deposited into this fund, but these transfers cannot exceed 20% of the appropriated amount for the fiscal year or period.

For FY2009 through FY2023, states with a funding shortfall and CHIP enrollment for children exceeding a state-specific target level receive a payment from the Child Enrollment Contingency Fund. This payment is equal to the amount by which the enrollment exceeds the target, multiplied by the product of projected per capita expenditures and the enhanced federal medical assistance percentage (E-FMAP), which is the federal share of CHIP expenditures.

Provision

Section 50101(c) extends the funding mechanism for the Child Enrollment Contingency Fund under SSA Section 2104(n) and payments from the fund for FY2024 through FY2027.

⁹ Since 1964, the Department of Health and Human Services (HHS) has published an annual series of data presenting total national health expenditures, which represents aggregate health care spending in the United States. These expenditures include personal health care, government public health activity, government administration, the net cost of health insurance, noncommercial biomedical research, and health care structures and equipment.

Section 50101(d): Extension of Qualifying States Option

Background

In a few situations, federal CHIP funding is used to finance Medicaid expenditures. For instance, certain states had significantly expanded Medicaid eligibility for children prior to the enactment of CHIP in 1997. These states are allowed to use their CHIP allotment funds to finance the difference between the Medicaid and CHIP matching rates (i.e., federal medical assistance percentage [FMAP] and E-FMAP rates, respectively) for the cost of Medicaid-eligible children in families with income above 133% of the federal poverty level (FPL). Eleven states meet the definition: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. This provision is referred to as the *qualifying states option*. Prior to the enactment of BBA 2018, FY2023 was the last year in which the qualifying states option was authorized.

Provision

Section 50101(d) extends the qualifying states option under SSA Section 2105(g)(4) for FY2024 through FY2027.

Section 50101(e): Extension of Express Lane Eligibility Option

Background

CHIPRA created a state plan option for Express Lane eligibility through September 30, 2013. Under this option, states are permitted to rely on a finding from specified Express Lane agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and the Supplemental Nutrition Assistance Program) for

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

This provision was extended through subsequent legislation. Most recently, P.L. 115-120 extended the Express Lane eligibility option through FY2023.

Provision

Section 50101(e) amends SSA Section 1902(e)(13)(I) to extend authority for Express Lane eligibility determinations for FY2024 through FY2027.

Section 50101(f): Assurance of Eligibility Standard for Children and Families

Background

Eligibility for Medicaid and CHIP is determined by both federal and state law, whereby states set individual eligibility criteria within federal standards. Statewide upper-income eligibility thresholds for CHIP-funded child coverage vary substantially across states, ranging from a low of

170% of FPL to a high of 400% of FPL, as of January 2017.¹⁰ The Centers for Medicare & Medicaid Services (CMS) administrative data show that CHIP enrollment is concentrated among families with annual income at lower levels. FY2013 state-reported administrative data show that approximately 99.4% of CHIP child enrollees were in families with annual income at or below 300% of FPL.¹¹

Under the ACA maintenance of effort (MOE) provisions, states are required to maintain their Medicaid programs with the same eligibility standards, methodologies, and procedures in place on the date of enactment of the ACA until January 1, 2014, for adults and through September 30, 2019, for children up to the age of 19 (SSA Section 1902(gg)(2)). The ACA also requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving payments under Medicaid (SSA Section 2105(d)(3)).¹² The penalty to states for not complying with either the Medicaid or the CHIP MOE requirements would be the loss of all federal Medicaid funds. The MOE requirement affects CHIP Medicaid expansion programs and separate CHIP programs differently.

- For CHIP Medicaid expansion programs, when federal CHIP funding is exhausted, the CHIP-eligible children in these programs will continue to be enrolled in Medicaid but financing will switch from CHIP to Medicaid.
- For separate CHIP programs, states are provided with two exceptions to the MOE requirement: (1) states may impose waiting lists or enrollment caps to limit CHIP expenditures, and (2) after September 1, 2015, states may enroll CHIP-eligible children in qualified health plans in the health insurance exchanges. In addition, in the event that a state's CHIP allotment is insufficient to fund CHIP coverage for all eligible children, a state must establish procedures to screen children for Medicaid eligibility and enroll those who are Medicaid eligible. For children not eligible for Medicaid, the state must establish procedures to enroll CHIP children in qualified health plans in the health insurance exchanges that have been certified by the Secretary of the Department of Health and Human Services (HHS) to be "at least comparable" to CHIP in terms of benefits and cost sharing.

P.L. 115-120 extended the Medicaid and CHIP MOE requirements for children for four years, from FY2020 through FY2023. However, for this period, the Medicaid and CHIP MOE requirements only apply to children in families with annual income less than 300% of FPL. During this specified period, states are permitted to roll back Medicaid and/or CHIP eligibility for children in families with annual income that exceeds 300% of FPL without the loss of all federal Medicaid matching funds.

Provision

Section 50101(f) extends the Medicaid (SSA Section 1902(gg)(2)) and CHIP (SSA Section 2105(d)(3)) MOE requirements for children for four years, from FY2024 through FY2027.

¹⁰ Medicaid and CHIP Payment and Access Commission (MACPAC), *Exhibit 35. Medicaid and CHIP Income Eligibility Levels as a Percentage of FPL for Children and Pregnant Women by State*, MACStats, January 2017.

¹¹ Centers for Medicare & Medicaid Services, Child Health Insurance Program Budget Report, based on Form 21E and 64.21E Combined, as of April 2014.

¹² For more information about the CHIP maintenance of effort requirement, see CRS Report R43909, *CHIP and the ACA Maintenance of Effort (MOE) Requirement: In Brief*.

Section 50102: Extension of Pediatric Quality Measures Program

Background

SSA Section 1139A authorizes a variety of activities related to pediatric quality measurement for health care provided under Medicaid or CHIP. Under SSA Section 1139A(a), the HHS Secretary was required to identify and publish an initial core set of pediatric quality measures by no later than January 1, 2010. SSA Section 1139A(b) required the Secretary to establish a Pediatric Quality Measures Program (PQMP) by January 1, 2011. This program is required to identify pediatric quality measure gaps and development priorities, award grants and contracts to develop measures, and revise and strengthen the core measure set, among other things. Section 1139A(c) requires states to submit reports to the Secretary annually to include information about state-specific child health quality measures applied by the state, among other things. Under Section 1139A(d), the Secretary also was required, between FY2009 and FY2013, to award no more than 10 grants to states and child health providers for demonstration projects to evaluate ideas to improve the quality of children's health care. In addition, the Secretary, not later than January 1, 2010, was required by Section 1139A(f) to establish a program to encourage the development and dissemination of a model electronic health record for children. The Institute of Medicine (IOM) was required under Section 1139A(g) to develop a report on the measurement of child health status and quality by no later than July 1, 2010.¹³

Funding for these activities was appropriated in the amount of \$45 million for each of FY2009 through FY2013. Section 210 of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) extended funding for only the PQMP for FY2014 by requiring that not less than \$15 million of the \$60 million appropriated for adult health quality measures under SSA Section 1139B(e) for FY2014 be used to carry out Section 1139A(b). The appropriation in Section 1139A(i) for funding to carry out Section 1139A (except for subsection (e)) expired in FY2013; the funding designated to carry out Section 1139A(b) expired in FY2014. MACRA Section 304(b) appropriated \$20 million for the period FY2016 through FY2017 for the purposes of carrying out SSA Section 1139A.

Section 3003(b) of P.L. 115-120 amended SSA Section 1139A(i) to appropriate funding in the amount of \$90 million for the period of FY2018 through FY2023 to be used to carry out the activities of Section 1139A. This funding remains available until expended, and is specifically excluded from being used to carry out the activities under subsections (e), (f), and (g).¹⁴

Provision

Section 50102(a) amends SSA Section 1139A(i) to appropriate \$60 million for the period of FY2024 through FY2027 to carry out specified pediatric quality measurement activities under the section (excluding subsections (e), (f) and (g)), including maintenance of a pediatric core quality measure set, identification of measure gaps, and development of measures. Section 50102(b)

¹³ The then Institute of Medicine (now National Academy of Medicine) published a report, "Child and Adolescent Health and Health Care Quality: Measuring What Matters," in fulfillment of the statutory requirement at 1139A(g) on April 25, 2011; AHRQ developed the Children's Electronic Health Record (EHR) Format in 2013 in fulfillment of the statutory requirement at 1139A(f). See <http://nationalacademies.org/hmd/reports/2011/child-and-adolescent-health-and-health-care-quality.aspx> and <https://healthit.ahrq.gov/health-it-tools-and-resources/pediatric-resources/childrens-electronic-health-record-ehr-format>.

¹⁴ These subsections are excluded because the authorized activities have either been completed or they are supported by a separate source of funding.

amends SSA Section 1139A subsections (a) and (c) to make annual state reporting to the HHS Secretary of the pediatric core measure set mandatory, beginning with the report on FY2024, and to modify the triennial reporting requirement from the HHS Secretary to Congress to include the status of mandatory reporting by states, beginning with the report required on January 1, 2025.¹⁵

Section 50103: Extension of Outreach and Enrollment Program

Background

CHIPRA Section 201 appropriated (out of funds in the Treasury that were not otherwise appropriated) \$100 million in outreach and enrollment grants for FY2009 through FY2013 to be used by eligible entities (e.g., states, local governments, community-based organizations, elementary and secondary schools) to conduct outreach and enrollment efforts that increase the participation of Medicaid and CHIP-eligible children.¹⁶ Of the total appropriation, 10% is directed to a national campaign to improve the enrollment of underserved child populations, and 10% is targeted to outreach for Native American children. The remaining 80% is distributed among eligible entities for the purpose of conducting outreach campaigns, focusing on rural areas and underserved populations. Grant funds also are targeted at proposals that address cultural and linguistic barriers to enrollment. The ACA appropriated \$140 million for FY2009 through FY2015 for outreach and enrollment grants. MACRA Section 303 appropriated \$40 million for FY2016 and FY2017 for outreach and enrollment grants.

Most recently, P.L. 115-120 amends SSA Section 2113(a)(1) and (g) to appropriate \$120 million for CHIP outreach and enrollment grants for the period of FY2018 through FY2023. The provision also adds *parent mentors* to the list of entities that are eligible to receive outreach and enrollment grants under SSA Section 2113(f). Parent mentors are defined as a parent or guardian of a child who is eligible for Medicaid or CHIP who is trained to assist families with uninsured children to improve social determinants of health. Such assistance may include educating families about how to obtain health insurance coverage, assisting families with completing (and submitting) health insurance coverage applications, serving as a liaison between families and representatives of Medicaid and CHIP, providing guidance to families on identifying medical and dental homes and community pharmacies for children, and providing assistance and referrals to families to address social determinants of children's health (e.g., poverty, food insufficiency and housing). The provision also requires such compensation to be disregarded when determining Medicaid modified adjusted gross income (MAGI)-based income eligibility for individuals acting as parent mentors.

Provision

Section 50103 amends SSA Section 2113(a)(1) and (g) to appropriate \$48 million for CHIP outreach and enrollment grants for the period of FY2024 through FY2027, and requires 10% of such funds to be set aside for use by the HHS Secretary for evaluations and technical assistance.

¹⁵ Technically, the report to which this language refers is not required on January 1, 2025, nor is it an annual report. The statutory reporting requirement at Section 1139A(a)(6) of the Social Security Act (SSA) states: "Not later than January 1, 2011, and every three years thereafter, the Secretary shall report to Congress on...." Section 1139A(A)(6)(B), the text directly amended by BBA 2018, required the report from the Secretary to Congress to include "the status of voluntary reporting by States ... using the initial core quality measurement set." The first report was published in January of 2011, so reports appear to be required every three years thereafter (e.g., 2014, 2017, 2020, 2023, 2026).

¹⁶ For more information on CHIP Outreach and Enrollment grants, see CRS Report R40821, *Medicaid and Children's Health Insurance Program (CHIP) Provisions in America's Affordable Health Choices Act of 2009 (H.R. 3200)*.

The provision also amends SSA Section 2113(h) to allow reserved national enrollment campaign funds to be used for technical assistance in the development of enrollment and retention strategies for underserved Medicaid and CHIP child populations.

Public Health Extenders

Section 50501: Extension for Family-to-Family Health Information Centers

Background

SSA Section 501(c) established the Family-to-Family Health Information Centers program, which funds family-staffed and family-run centers in the 50 states and the District of Columbia. The Family-to-Family Health Information Centers provide information, education, technical assistance, and peer support to families of children (including youth) with special health care needs and health professionals who serve such families. In addition, the centers help ensure that families and health professionals are partners in decisionmaking at all levels of care and service delivery.¹⁷ The Health Resources and Services Administration (HRSA) administers this program. The program began in 2005 as part of the Deficit Reduction Act of 2005 (DRA; P.L. 109-171). The Family-to-Family Health Information Centers received an annual direct appropriation of \$3 million for FY2007, which increased to \$5 million for each of FY2009 through FY2017. The program's appropriation was most recently extended in MACRA.

Provision

Section 50501 amends SSA Section 501(c) to extend funding for the Family-to-Family Health Information Centers program for FY2018 and FY2019 by providing \$6 million in each year. It also amends SSA Section 501(c) to require that Family-to-Family Health Information Centers be developed in all of the territories (as defined)¹⁸ and that at least one center be developed for Indian tribes. It defines the terms “Indian Tribe,” “State,” and “territory.”

Section 50502: Extension for Sexual Risk Avoidance Education

Section 50502 replaces SSA Section 510 with new language. The following provides the background and provision description for each subsection of the new SSA Section 510.

Background SSA Section 510: Name Change

The 1996 welfare reform law (P.L. 104-193) established a “Separate Program for Abstinence Education” under SSA Section 510. The program—commonly referred to as the Title V Abstinence Education Grant program—is to fund states and territories in providing abstinence education and (optionally, where appropriate) mentoring, counseling, and adult supervision “with a focus on those groups which are most likely to bear children out-of wedlock.” The law does not define such groups. In practice, Abstinence Education funding has been used generally for children in elementary through high school.

¹⁷ For more information, see “Children with Special Needs,” at <https://mchb.hrsa.gov/maternal-child-health-initiatives/mchb-programs>.

¹⁸ The territories are Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

Provision SSA Section 510

Section 50502 amends SSA Section 510 by renaming the program as the Sexual Risk Avoidance Education program.

Background SSA Section 510(a): Funding Allocation

As specified in the law, states (including territories) are eligible to request Title V Abstinence Education Grant funds for a given fiscal year if they submit an application for Maternal and Child Health (MCH) Services Block Grant funds for that same fiscal year.¹⁹ The MCH Services Block Grant, authorized under Title V of the Social Security Act, is a flexible source of funds that states use to support maternal and child health programs.²⁰ Abstinence Education Grant funds are allocated to each jurisdiction based on its relative proportion of low-income children nationally.²¹

The FY2015 annual appropriations law (P.L. 113-235) included a provision that enabled HHS to reallocate FY2015 Abstinence Education funds that would have been designated for states that did not apply for the funds. These FY2015 funds were available only to states that had applied for the funds, and states could use them to implement elements described in “abstinence education,” as the term is defined in the law. MACRA extended this language to program funding for FY2016 and FY2017.²²

Provision SSA Section 510(a)

Section 50502 provides that FY2018 and FY2019 Sexual Risk Avoidance Education allotments are to be made to states (and territories) that have applied for MCH Services Block Grant funds. Allotments are based on two factors. First, funding is available based on the amount provided to the program minus any reservations (up to 20%) made by HHS for administering the program.

¹⁹ SSA Section 510(a), which references the MCH Services Block Grant application requirements at Section 505(a).

²⁰ For further information, see CRS Report R44929, *Maternal and Child Health Services Block Grant: Background and Funding*. All states, the District of Columbia, and eight territories (American Samoa, Federated States of Micronesia, Guam, Northern Mariana Islands, Republic of the Marshall Islands, Republic of Palau, Puerto Rico, and the Virgin Islands) receive MCH Services Block Grant funds and therefore are eligible to apply for Title V Abstinence Education funds. In FY2017, 37 states and two territories (Puerto Rico and the Federated States of Micronesia) applied for Abstinence Education funding. The states are Alabama, Alaska, Arkansas, Colorado, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, and Wisconsin. For further information, see HHS, Administration for Children and Families (ACF), Family and Youth Services Bureau (FYSB), “2017 Title V State Abstinence Education Program Grant Awards,” January 19, 2017, <https://www.acf.hhs.gov/fysb/resource/2017-aegp-awards>.

²¹ Section 510(a)(2) of the Social Security Act, which references the MCH Services Block Grant at Section 502(c)(1)(B)(ii). Census data are not available for the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau. Thus, the allocations for these three entities, when applicable, are based on the amounts allocated to them by HHS in prior fiscal years. Jurisdictions can choose to make subawards to local organizations and may focus on youth in specific geographic areas (e.g., urban, rural, suburban). HHS, ACF, FYSB, *Title V State Abstinence Education Grant Program Combined FY 2016 and FY 2017 Announcement*, HHS-2016-ACF-ACYF-AEGP-1131. (Hereinafter, HHS, ACF, FYSB, *Title V State Abstinence Education Grant Program Combined FY 2016 and FY 2017 Announcement*.)

²² P.L. 113-235 and MACRA did not amend Title V of the Social Security Act. Rather, these laws included stand-alone provisions that applied only to funding for FY2015 through FY2017.

Second, funds are allocated to states based on their relative proportion of low-income children nationally.²³

Further, Section 50502 enables HHS to competitively award FY2018 and FY2019 funds to one or more entities within a state/territory that had not previously applied for its share of funding. The entity or entities would receive the amount that would have been otherwise allotted to that state. The HHS Secretary is required to publish a notice to solicit grant applications for the remaining competitive funds. The solicitation must be published within 30 days after the deadline for states to apply for MCH Services Block Grant funds. Eligible states are required to apply for the Sexual Risk Avoidance Education funds no later than 120 days after the deadline closed for states to apply for MCH Services Block Grant funds.

Background SSA Section 510(b): Purposes

Title V Abstinence Education Grant funds must be used exclusively for teaching abstinence and may not be used in conjunction with, or for, any other purpose. The law defines the term “abstinence education” as an educational or motivational program that

- has as its exclusive purpose teaching the social, psychological, and health gains of abstaining from sexual activity;
- teaches that abstinence from sexual activity outside of marriage is the expected standard for all school-age children;
- teaches that abstinence is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted infections (STIs), and associated health problems;
- teaches that a mutually faithful monogamous relationship within marriage is the expected standard of human sexual activity;
- teaches that sexual activity outside of marriage is likely to have harmful psychological and physical effects;
- teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society;
- teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- teaches the importance of attaining self-sufficiency before engaging in sex.

Provision SSA Section 510(b)

Section 50502 amends SSA Section 510 to specify that Sexual Risk Avoidance Education program funds are available to a state or other entity (in a state that did not apply for funds) to implement education exclusively on sexual risk avoidance, meaning voluntarily refraining from sexual activity. This requirement does not apply to research conducted by the state or other entity *or* to information that the state or entity may collect under the program.

States or other entities are required to implement sexual risk avoidance education that is medically accurate and complete, age-appropriate, and based on adolescent learning and developmental theories for the age group receiving the education. The education must also be culturally appropriate, recognizing the experiences of youth from diverse communities,

²³ Unlike preexisting law, this provision does not reference the MCH Services Block Grant requirement on distributing funds based on relative proportion of low-income children.

backgrounds, and experiences. In addition, sexual risk avoidance education must ensure that the “unambiguous and primary emphasis and context” for each of six sexual risk avoidance topics is “a message to youth that normalizes the optimal health behavior of avoiding nonmarital sexual activity.” The sexual risk avoidance topics include the following:

- The holistic individual and societal benefits associated with personal responsibility, self-regulation, goal setting, healthy decisionmaking, and a focus on the future.
- The advantage of refraining from nonmarital sexual activity in order to improve the future prospects and physical and emotional health of youth.
- The increased likelihood of avoiding poverty when youth attain self-sufficiency and emotional maturity before engaging in sexual activity.
- The foundational components of healthy relationships and their impact on the formation of healthy marriages and safe and stable families.
- How other youth risk behaviors, such as drug and alcohol usage, increase the risk for teen sex.
- How to resist, avoid, and receive help regarding sexual coercion and dating violence, recognizing that even with consent teen sex remains a youth risk behavior.

If sexual risk avoidance education includes any information about contraception, such information must be medically accurate and must help students understand that contraception reduces physical risk but does not eliminate risk. In addition, sexual risk avoidance education may not include demonstration, simulations, or distribution of such contraception devices.

Background SSA Section 510(c): Research and Data Requirements

Title V of the Social Security Act does not address evaluation activities for the Abstinence Education Grant program; however, the BBA97 directed HHS to conduct evaluation activities of the Title V Abstinence Education program.²⁴

Provision SSA Section 510(c)

Section 50502 amends SSA Section 510 to specify that a state or other entity receiving funding under the Sexual Risk Avoidance Education program may use up to 20% of such allotment to build the evidence base for sexual risk avoidance by conducting or supporting research. Any such research must be rigorous, evidence-based, and designed and conducted by independent researchers who have experience in conducting and publishing research in peer-reviewed outlets.

²⁴ This was a stand-alone provision that did not amend Title V of the Social Security Act. In response, HHS undertook a multiyear evaluation that involved a study of how grantees in four states implemented abstinence education programs and a separate study that rigorously evaluated whether grantees’ programs had impacts on teen sexual abstinence and related outcomes. The impact evaluation found that youth who received abstinence education under the program did not have different outcomes than those youth in the control group. Barbara Devaney, *The Evaluation of Abstinence Education Programs Funded Under Title V Section 510: Interim Report*, Mathematica Policy Research, Inc., for HHS, ACF, Assistant Secretary for Planning and Evaluation (ASPE), April 2002; and Christopher Trenholm et al., *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report*, Mathematica Policy Research, Inc. for HHS, ACF, ASPE, April 2007.

A state or other entity that receives Sexual Risk Avoidance Education grants must, as specified by the HHS Secretary, collect information on the programs and activities funded through their allotments and submit reports to HHS on the data collected from such programs and activities.

Separately, HHS is required to conduct one or more rigorous evaluations of the education (and associated data) funded through the Sexual Risk Avoidance Education program. This evaluation is to be conducted in consultation with “appropriate State and local agencies.” HHS is to consult with relevant stakeholders and evaluation experts about the evaluation(s). HHS must submit a report to Congress on the results of the evaluation(s). The report must also include a summary of the information collected and reported by states and other entities on their Sexual Risk Avoidance Education programs and activities.

Background SSA Section 510(d): Application of MCH Services Block Grant Provisions

SSA Section 510 specified that selected sections of the act that apply to allotments made under the MCH Services Block Grant—including SSA Sections 503 (Payments to states), 507 (Criminal penalty for false statement), and 508 (Nondiscrimination)—also applied in the same way to the allotments made under the Abstinence Education program. In addition, the HHS Secretary was able to determine the extent to which other sections, SSA Section 505 (Application for block grant funds) and SSA Section 506 (Reports and audits), also applied to Abstinence Education allotments.

Provision SSA Section 510(d)

Section 50502 specifies that SSA Sections 503, 507, and 508 apply to allotments under the MCH Services Block Grant continue to also apply to allotments under the Sexual Risk Avoidance Education program.²⁵ HHS continues to have discretion in determining the extent to which the provisions under SSA Sections 505 and 506 apply.

Background SSA Section 510(e): Definitions

SSA Section 510 did not previously include definitions.

Provision SSA Section 510(e)

Section 50502 adds four definitions to SSA Section 510 under the new SSA Section 510(e):

- “Age-appropriate”: suitable (in terms of topics, messages, and teaching methods) to the developmental and social maturity of the particular age or age group of children or adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.
- “Medically accurate and complete”: verified or supported by the weight of research conducted in compliance with accepted scientific methods and (1) published in peer-reviewed journals, where applicable; or (2) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

²⁵ As amended by the Consolidated Appropriations Act, 2018 (P.L. 115-141), a state match requirement for the MCH Services Block Grant under Section 503 no longer applies to the Title V Abstinence Education Program.

- “Rigorous”: With respect to research and evaluation, means using (1) established scientific methods for ensuring the impact of an intervention or program model in changing behavior (specifically sexual activity or other risk behaviors), or reducing pregnancy, among youth; or (2) other evidence-based methodologies established by the Secretary for purposes of the Sexual Risk Avoidance Education program.
- “Youth”: One or more individuals aged 10 through 19.

Background SSA Section 510(f): Funding

The Title V Abstinence Education Grant program has been funded through mandatory funds. P.L. 104-193 provided \$50 million to the program per year for five years (FY1998-FY2002). Subsequently, the grant was funded through various extensions of that spending. Most recently, MACRA increased funding for the program to \$75 million per year for FY2016 and FY2017.

Provision SSA Section 510(f)

Section 50502 amends SSA Section 510 under the new SSA Section 510(f) to provide \$75 million in mandatory funds to the Sexual Risk Avoidance Education program for each of FY2018 and FY2019.

The HHS Secretary is required to reserve, for each of these two years, up to 20% of the funding for administering the program. Such administrative funding includes funding for HHS to conduct a national evaluation(s) of the program and provide technical assistance to states that receive funding.

Section 50502(b): Effective Date for Extension for Sexual Risk Avoidance Education

Background

Under prior law, the SSA Section 510 provisions were generally applied to grants made through FY2017.

Provision

Section 50502(b) makes the new program included in Section 50502(a) effective retroactive to the start of FY2018, or October 1, 2017.

Section 50503: Extension for Personal Responsibility Education

Background

ACA Section 2953 established the Personal Responsibility Education Program (PREP) under SSA Section 513. The program is a broad approach to teen pregnancy prevention that seeks to educate adolescents aged 10 through 19 and pregnant and parenting youth under age 21 on both abstinence and contraceptives to prevent pregnancy and STIs. The ACA provided \$75 million annually in mandatory spending for each of five fiscal years (FY2010 through FY2014). PREP authorization had been most recently extended, by MACRA, for FY2015 through FY2017.

All states, the District of Columbia, and all territories are eligible for state PREP funding. Funds are allocated by formula, based on the proportion of youth aged 10 through 19 in each jurisdiction relative to other jurisdictions. If a state or territory did not submit an application for formula funding in FY2010 or FY2011, it was ineligible to apply for funding for each of FY2010 through FY2017. Local organizations, including faith-based organizations or consortia, in such a state or territory were eligible to competitively apply for funding. The law specifies that funding is to be provided as three-year grants to carry out programs and activities that would have otherwise been carried out by the state. In practice, HHS refers to these “3-Year Grants” (per the law) as Competitive PREP grants.²⁶

HHS also provides PREP grants to Indian tribes and tribal organizations (known as Tribal PREP), as well as grants to implement innovative strategies (known as PREIS, or Personal Responsibility Education Program Innovative Strategies). Tribal PREP grants are intended to support projects that educate American Indian and Alaska Native youth, including pregnant and parenting youth, on both abstinence and contraceptives to prevent pregnancy and STIs. PREIS grants are intended to build evidence on promising teen pregnancy prevention programs for high-risk, vulnerable, and culturally underrepresented youth populations. The law specifies that these populations include youth aged 10 to 20 in foster care, homeless youth, youth with HIV/AIDS, pregnant and parenting women who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth.

Provision

Section 50503 amends SSA Section 513 to provide \$75 million for PREP in each of FY2018 and FY2019. It specifies that the competitive “3-Year Grants” are now referred to in law as “Competitive PREP Grants.” Further, it extends the requirement that states are not eligible to submit an application for funding, through FY2019, if they did not submit an application in FY2010 and FY2011. The Competitive PREP grants that were awarded for any of FY2015 through FY2017 in such states are to continue for an additional two years, through FY2019. In addition, it specifies that victims of human trafficking are considered high-risk, vulnerable, and culturally underrepresented youth for purposes of the PREIS program. The amendments are retroactively effective as of October 1, 2017.

Section 50611: Extension of Health Workforce Demonstration Projects for Low-Income Individuals

Background

ACA Section 5507(a) required the HHS Secretary to establish a demonstration project in SSA Section 2008 to award funds to states, Indian tribes, institutions of higher education, and local workforce investment boards for health profession opportunity grants (HPOG). These grants were used to help low-income individuals—including individuals receiving assistance from state Temporary Assistance for Needy Families programs—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. This program is administered jointly by HRSA and ACF. The ACA provided \$85 million in mandatory funding for HPOG in each of FY2010-FY2014 (\$425 million total), but a total of \$15 million was reserved for a demonstration project for personal and home

²⁶ HHS has awarded Competitive PREP funding for FY2012 through FY2014 to organizations that declined funding in FY2010 or FY2011, and has awarded Competitive PREP funding for FY2015 through FY2017 to organizations in states that declined funding in FY2016 and FY2017.

care aides. The program's funding has been extended twice, most recently in MACRA, which provided \$85 million for each of FY2016 and FY2017.

Provision

This section amends SSA Section 208(c)(1) to extend HPOG funding through FY2019. Specifically, the provision provides \$85 million in mandatory funding for the program for each of FY2018 and FY2019.

Section 50901(a): Extension for Community Health Centers

Background

The health center program, authorized by Section 330 of the Public Health Service Act (PHSA), provides grants to not-for-profit or state and local government entities to operate outpatient health centers. These centers are required to be located in medically underserved areas (MUAs) or to provide care to a population that is designated as underserved.²⁷

Historically, the health center program had generally been supported with discretionary appropriations; however, in 2010, the ACA created the Community Health Center Fund (CHCF), which provided mandatory funding for the program. The ACA appropriated a total of \$9.5 billion to the fund 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.

Mandatory funding for the CHCF was subsequently extended as part of MACRA, which provided \$3.6 billion for each of FY2016 and FY2017. The mandatory CHCF appropriations are provided in addition to discretionary funding for the program; however, the CHCF comprised approximately 72% of health center programs' appropriations in FY2017.²⁸ At the start of FY2018, no funds were appropriated for the CHCF; funding was later provided in P.L. 115-96 (Division C—Health Provisions of the Further Additional Continuing Appropriations Act, 2018), which provided \$550 million for the first two quarters of FY2018.

Provision

Section 50901(a) amends ACA Section 10503(b)(1)(F) to replace language included in P.L. 115-96 with a longer extension of the CHCF's mandatory funding. Specifically, it provides \$3.8 billion for the CHCF for FY2018 and \$4.0 billion for FY2019.

²⁷ For more information about these designations, see CRS Report R43937, *Federal Health Centers: An Overview*.

²⁸ CRS Insight IN10804, *Two-Year Extension of the Community Health Center Fund*.

Section 50901(b): Other Community Health Centers Provisions

Background

PHSA Section 330 health center grants are awarded competitively, with some preference given to sites in rural areas. The program has a number of grant programs, including, but not limited to, grants to support health center operations, grants to enable health centers to expand services, and grants for health centers to engage in quality improvement activities.²⁹ The health center program supports four types of health centers: (1) community health centers, (2) health centers for the homeless, (3) health centers for residents of public housing, and (4) migrant health centers. Community health centers (CHCs) are the most numerous because they provide care to a generally underserved population. The remaining three types are less common because each serves more targeted subpopulations of the underserved than do CHCs.

All four types of health centers are required to provide primary health services and preventive and emergency health services.³⁰ Primary health services are those provided by physicians³¹ or physician extenders (physicians' assistants, nurse practitioners, and nurse midwives) to diagnose, treat, or refer patients. Primary health services include relevant diagnostic laboratory and radiology services. Preventive health services include well-child care, prenatal and postpartum care, immunization, family planning, health education, and preventive dental care.³² Emergency health services refer to the requirement that health centers have defined arrangements with outside providers for emergent cases that the center is not equipped to treat and for after-hours care. Health centers are also required to provide additional health services that are not primary health services but are necessary to meet the health needs of the service population. This includes, but is not limited to, behavioral health services and environmental health services.

Provision

Section 50901(b) amends PHSA Section 330 to make a number of changes to the health center program. It modifies references to "substance abuse" to "substance use disorder" throughout the authorization of the health center program in PHSA Section 330. It deletes the authorization for a number of health center grant programs that are no longer operational. Specifically, it deletes authorizations of grants for (1) Managed Care Network and Plans and (2) Practice Management Networks. It also strikes language that specified how funds under those grants programs could be used, and it makes conforming changes throughout the section to remove reference to "plans." The subsection makes a number of changes to grant programs authorized in PHSA Section 330 as follows.

Grants for Evidence-Based Models

Section 50901(b) eliminates an existing loan guarantee program and replaces the existing language with language that authorizes the HHS Secretary to make supplemental funding awards

²⁹ See "Grants that Support Health Centers" section in CRS Report R43937, *Federal Health Centers: An Overview*.

³⁰ 42 C.F.R. 51c.102(h). Health centers for the homeless, health centers for residents of public housing, and migrant health centers are also required to provide additional services to meet the needs of their service populations.

³¹ Ibid. The regulation further specifies that these services should be provided by primary care physicians, who are defined as physicians in family practice, internal medicine, pediatrics, or obstetrics and gynecology or, where appropriate, that these services may be provided by physician assistants, nurse practitioners, or nurse midwives.

³² The family planning and preventive screening services that health centers provide are discussed in CRS Report R44295, *Factors Related to the Use of Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FQHCs)*.

to existing centers to implement evidence-based models for improving access to high-quality primary care services. Evidence-based models include models related to improving the delivery of care for individuals with multiple chronic conditions, altering workforce configurations, reducing the cost of care, enhancing care coordination, expanding the use of telehealth, integrating primary care and behavioral health services, and addressing emerging public health or substance use disorder issues. The provision also authorizes the Secretary, when making these new supplemental grant awards, to consider whether the applicant health center has submitted a plan for continuing the proposed quality improvement activities after the supplemental funding award has ended. The subsection also authorizes the Secretary to give special consideration to applications for supplemental activities that seek to address significant barriers to access to care in areas where provider shortages are greater than the national average.

Operating Grants

Subsection 50901(b) makes the following changes to the operating grant program in PHSA Section 330(e)(1). First, it shortens the award period from two years to one year for entities that are unable to comply with all of the health center program requirements. It also prohibits the HHS Secretary from making an operating grant to a noncompliant center unless the applicant can provide assurance that within 120 days of receiving grant funding it will submit an implementation plan to meet the health center program's requirements. The subsection also permits the Secretary to extend the 120-day period if the health center demonstrates good cause. Second, the subsection adds language to permit operating grant funds to be used to purchase (1) data and information systems; (2) training and technical assistance; and (3) other activities that aim to reduce the costs associated with providing health services, improve health care access, enhance the quality and coordination of services that health centers provide, and improve the health status of communities.

New Access Points Grants

Section 50901(b) adds a new PHSA Section 330(e)(6) related to grants for "New Access Points and Expanded Services." PHSA Section 330(e)(6)(A) permits the HHS Secretary to make these grants to health centers to establish new delivery sites and adds language giving special consideration to applicants that demonstrate that the new delivery site will be located in either a sparsely populated area or an area with a high level of unmet need relative to other applicants. The provision also specifies that when making these awards, the Secretary is required to ensure that the ratio of awards to health centers that serve rural populations relative to those that serve urban populations is not less than a two-to-three ratio or greater than a three-to-two ratio. The provision also authorizes the Secretary to consider when making grants where an applicant for a new delivery site would overlap the catchment area of an existing delivery site, and whether such overlap is justified based on the unmet needs of the population that the applicant proposes to serve (i.e., its catchment area).

Expanded Service Grants

Section 50901(b) adds new language in PHSA Section 330(e)(6)(B) related to approving expanded service applications. It authorizes the HHS Secretary to approve applications for grants that would expand the capacity of health centers to provide required primary health services or additional services. It also authorizes the Secretary to give special consideration to applicants that propose to expand services to address emerging public health or behavioral health issues through increasing the availability of additional health services in areas in which there are significant barriers to accessing care. The provision also specifies that when making these awards, the Secretary is required to ensure that the ratio of awards to health centers that serve rural

populations relative to those that serve urban populations is not less than a two-to-three ratio or greater than a three-to-two ratio.

Health Centers for the Homeless

Section 50901(b) also amends PHSA Section 330(h) to add language specifying that grants for Health Centers for the Homeless include homeless veterans and veterans at risk of homelessness in their target service population.

Health Center Grant Applications

Section 50901(b) amends PHSA Section 330(k), related to health center application requirements, to specify that applicants describe the unmet health services needs of their service areas. In addition, the provision requires that applicants demonstrate that they have consulted with appropriate state and local government agencies and health care providers regarding the need for health services at the proposed delivery site. It amends the HHS Secretary's requirements when approving a grant to broaden the requirements associated with assessing whether the health center has made efforts to establish relationships with health care providers in its catchment area. Specifically, it adds language that requires the Secretary to consider whether the health center has made efforts to collaborate with other health care providers in its catchment areas, including local hospitals and specialty providers, with the goal of increasing collaboration with these providers to reduce the nonurgent use of hospital emergency departments for nonurgent conditions.

Health Center Governance, Technical Assistance, and Auditing Requirements

Section 50901(b) amends various PHSA Section 330 subsections. Specifically, it amends language regarding a health center's governing board to specify that it must approve the health center director, who is required to be directly employed by the center, and adds new language requiring the health center to have in place written policies to ensure the appropriate use of federal funds, in accordance with applicable federal statute, regulations, and the terms and conditions of the federal grant. It restricts the funds available for technical assistance and operational support activities to an amount that shall not exceed 3% of the funds appropriated for this section in a given fiscal year. It restricts the HHS Secretary's authority to waive a health center's auditing requirements to one year without the ability to extend the waiver into the next consecutive year.

Health Center Reporting

Section 50901(b) amends PHSA Section 330(r)(3) to specify which congressional committees would receive the required health center funding report and adds new reporting requirements, including (1) funding distribution by geography and grant types, (2) information on unexpended funding and funding for loan guarantees authorized in PHSA Title XVI,³³ and (3) information on health center closures, among others.

Health Center Research Project Participation

Section 50901(b) adds a new PHSA Section 330(r)(5) that appropriates \$25 million for FY2018 to support the participation of health centers in the "All of Us Research Program," part of the Precision Medicine Initiative (PMI) under PHSA Section 498E.³⁴ The subsection specifies that

³³ PHSA Title XVI (42 U.S.C. §§300q through 300t-14), among other things, provided funds or guaranteed loans to convert hospitals to other types of health care facilities.

³⁴ For information about the All of Us Research Program, see U.S. Department of Health and Human Services, National Institutes of Health, "All of Us Research Program," <https://allofus.nih.gov/>.

the funding is in addition to (1) funds made available to the CHCF under this provision, (2) funds previously made available to the CHCF, and (3) funds made available to the National Institutes of Health.³⁵

Individualized Wellness Plans

Section 50901(b) deletes PHSA Section 330(s), which had authorized grants for a pilot program to develop individualized wellness plans at not more than 10 CHCs.

Section 50901(c): Extension for the National Health Service Corps

Background

The CHCF also provides mandatory funding for the National Health Service Corps (NHSC), authorized in Title III of the PHSA.³⁶ The NHSC provides scholarships and loan repayments to certain health professionals in exchange for providing care in a health professional shortage area (HPSA) for a period of time that varies based on the length of the scholarship or the number of years of loan repayment received.³⁷ This program last received discretionary appropriations in FY2011; since that time, CHCF funds have been the sole source of NHSC funding. At the start of FY2018, no funds were appropriated for the CHCF; funding was later provided in P.L. 115-96 (Division C—Health Provisions of the Further Additional Continuing Appropriations Act, 2018), which provided \$65 million for the first two quarters of FY2018.

Provision

Section 50901(c) amends ACA Section 10503(b)(2)(F) to replace language included in P.L. 115-96 to extend mandatory funding for the NHSC funding for a longer time period. Specifically, it provides \$310 million for each of FY2018 and FY2019.

Section 50901(d): Extension for Teaching Health Centers that Operate GME Programs

Background

PHSA Section 340H provides direct and indirect graduate medical education (GME) payments to support medical and dental residents training at qualified teaching health centers, which are outpatient health care facilities that provide care to underserved patients. ACA Section 5508(c) created and provided \$230 million in mandatory funding for the Teaching Health Center Graduate Medical Education Program (THCGME) for the period of FY2011 through FY2015.³⁸ Program funding was subsequently extended in MACRA, which appropriated \$60 million for each of FY2016 and FY2017 for direct and indirect GME payments for teaching health centers. MACRA

³⁵ For information about funding for the National Institutes of Health (NIH), see NIH section in CRS Report R44916, *Public Health Service Agencies: Overview and Funding (FY2016-FY2018)*.

³⁶ For more information about the National Health Service Corps, see CRS Report R44970, *The National Health Service Corps*.

³⁷ Health professional shortage areas (HPSAs) are defined in 42 U.S.C. §254e. See U.S. Department of Health and Human Services, Health Resources and Services Administration, “Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P),” <https://bhwh.hrsa.gov/shortage-designation>.

³⁸ For more information about the Teaching Health Center Graduate Medical Education Program see CRS Insight IN10728, *The Teaching Health Center Graduate Medical Education (THCGME) Program: Increased Funding and Policy Changes in BBA 2018*.

funds were used to fund residents at existing teaching health center programs; no new teaching health centers were added to the program. FY2018 funding has been provided in two laws that each provided one-quarter of funding; specifically, funding for the first quarter of FY2018 was provided by the Disaster Tax Relief and Airport and Airway Extension Act of 2017 (P.L. 115-63), which provided \$15 million for the first quarter of FY2018, and in P.L. 115-96 (Division C—Health Provisions of the Further Additional Continuing Appropriations Act, 2018), which struck the \$15 million that had been provided for the first quarter of FY2018 and appropriated \$30 million for the first two quarters of FY2018.

Provision

Section 50901(d) amends PHSA Section 340H to make several changes to the THCGME. It permits payments to be made to support the residency training of (1) the current number of trainees in existing programs, (2) new residents trained in existing programs, and (3) new residents training in new programs. When making payments under this section, the HHS Secretary is required to consider the costs of training residents at teaching health centers and the implications of the per-resident amount on approved graduate medical residency training programs at Teaching Health Centers. With regard to newly established residency programs, the provision gives funding preference to programs in HPSAs/MUAs or programs located in rural areas. The provision strikes the \$30 million provided for the first two quarters of FY2018 and instead provides \$126.5 million for each of FY2018 and FY2019, to remain available until expended.

The subsection amends PHSA Section 340H(h) to modify the program’s reporting requirements to require additional data on (1) the volume of care provided by residents supported under the program and (2) the number and percentage of graduated residents who enter into primary care practice and the number and percentage of graduated residents who do so in an HPSA, MUA, or a rural area. The provision also requires that the HHS Secretary submit a report to Congress not later than March 31, 2019, on the direct and indirect expenses associated with the additional costs of teaching residents at teaching health centers. It defines the term “new approved graduate medical residency training program” and specifies that the requirements for THCGME that were in effect prior to enactment will remain in effect with respect to THCGME payments made for fiscal years prior to FY2018.

Section 50901(e): Funding Restrictions

Background

Under federal law, federal funds are generally not available to pay for abortions, except in cases of rape, incest, or endangerment of a mother’s life. This restriction is the result of statutory and legislative provisions like the Hyde Amendment, which has been added to the annual appropriations measure for HHS since 1976. This prohibition was most recently included in the Consolidated Appropriations Act, 2017 (P.L. 115-31).

Provision

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 NHSC, and qualified teaching health centers for FY2018 and FY2019.³⁹

Section 50901(f): Health Services for Victims of Human Trafficking

Background

The Justice for Victims of Trafficking (P.L. 114-22) permitted that between \$5 million and \$30 million of funds appropriated to the CHCF could be transferred to the Department of Justice (DOJ) to be used for health services for victims of human trafficking.

Provision

Section 50901(f) amends 18 U.S.C. 3014(h) to continue the authority for HHS to transfer funds to DOJ for victims of human trafficking for the time period of the CHCF funding extension (i.e., FY2018 and FY2019).

Section 50902: Extension for Special Diabetes Programs

Background

PHSA Section 330 B authorizes the Special Diabetes Program for Type I Diabetes that provides funding for the National Institutes of Health (NIH) to award grants for research into the prevention and cure of type I diabetes. PHSA Section 330C authorizes the Special Diabetes Program for Indians, which 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

³⁹ Specifically, Division H, Title V, Sections 506 and 507 of P.L. 115-31 state that

(a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion. (b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion. (c) The term “health benefits coverage” means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement. §507. (a) The limitations established in the preceding section shall not apply to an abortion—(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. (b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State’s or locality’s contribution of Medicaid matching funds). (c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State’s or locality’s contribution of Medicaid matching funds). (d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. (2) In this subsection, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

Natives who receive services at IHS-funded facilities. These programs were created in the BBA97, which transferred \$30 million annually from CHIP funds to each program from FY1998 through FY2002. The program's funding was extended and increased in subsequent legislation. For example, MACRA provided \$150 million for each program for each of FY2016 and FY2017. These programs had been funded in tandem; however, the Special Diabetes Program for Indians received \$37.5 million in the Disaster Tax Relief and Airport and Airway Extension Act of 2017 (P.L. 115-63) for the first quarter of FY2018 while no funding was provided for the Special Diabetes Program for Type I Diabetes. Both programs were later provided with funding in P.L. 115-96 (Division C—Health Provisions of the Further Additional Continuing Appropriations Act, 2018), which provided \$37.5 million for the first and second quarters of FY2018 for the Special Diabetes Program for Type I Diabetes and \$37.5 million for the second quarter of FY2018 for the Special Diabetes Programs for Indians.

Provision

Section 50902 amends PHSA Section 330B and PHSA Section 330C to replace the funding language included in P.L. 115-96 with new language that provides longer funding extensions for the two Special Diabetes Programs. Specifically, it provides \$150 million in mandatory funding for each of FY2018 and FY2019 for the Special Diabetes Program for Type I Diabetes and amends PHSA Section 330C to provide \$150 million in mandatory funding for each of FY2018 and FY2019 for the Special Diabetes Program for Indians. Funds for both programs are to remain available until expended.

Section 53119: Prevention and Public Health Fund

Background

ACA Section 4002 established the Prevention and Public Health Fund (PPHF), to be administered by the HHS Secretary, and provided it with a permanent annual appropriation.⁴⁰ The PPHF is intended to support an “expanded and sustained national investment in prevention and public health programs.” In general, PPHF funds have been distributed to HHS agencies in the Public Health Service, in particular the Centers for Disease Control and Prevention. Amounts for each fiscal year are available to the HHS Secretary beginning October 1, the start of the respective fiscal year. Congress may explicitly direct the distribution of PPHF funds and did so for FY2014 through FY2018.

Under the ACA, the PPHF's annual appropriation would increase from \$500 million for FY2010 to \$2 billion for FY2015 and each subsequent fiscal year. BBA 2018 marks the fourth time Congress has reduced PPHF appropriations since then, using a portion of the Fund as an offset for the costs of other activities.

Provision

Section 53119 amends ACA Section 4002 to repeal \$1.35 billion in appropriations to the PPHF 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. Annual appropriations to the PPHF in current law, reflecting BBA 2018, are as follows:

⁴⁰ 42 U.S.C. §300u-11. For more information, see CRS Report R44796, *The ACA Prevention and Public Health Fund: In Brief*.

- \$500 million for FY2010,
- \$1.0 billion for each of FY2012 through FY2017,⁴¹
- \$900 million for each of FY2018 and FY2019,
- \$950 million for each of FY2020 and FY2021,
- \$1.0 billion for each of FY2022 and FY2023,
- \$1.3 billion for each of FY2024 and FY2025,
- \$1.8 billion for each of FY2026 and FY2027, and
- \$2.0 billion for FY2028 and each fiscal year thereafter.⁴²

Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)

Section 50601: Continuing Evidence-Based Home Visiting Program

Background

ACA Section 2951 established the MIECHV program at SSA Section 511. It provides grants to states, territories, and tribes (“eligible entities”) for the support of evidence-based early childhood home visiting. Home visiting entails in-home visits by health or social service professionals with at-risk families. The program is funded through mandatory spending. The ACA provided a total of \$1.5 billion for FY2010 through FY2014 for the home visitation grant program. Subsequently, the program was funded through various extensions of that funding. Most recently, MACRA had increased funding for the program to \$400 million annually for FY2016 and FY2017.

Provision

Section 50601 amends SSA Section 511(j) to provide mandatory funding of \$400 million for the MIECHV program for each of FY2017 through FY2022.

Section 50602: Continuing to Demonstrate Results to Help Families

Background

Eligible entities must establish, subject to approval of the HHS Secretary, quantifiable and measurable benchmarks for demonstrating improvements for eligible families participating in the program in each of six areas: (1) improved maternal and newborn health; (2) prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; (3) improvements in school readiness and achievement; (4) reduction in crime or domestic violence; (5) improvements in family economic self-sufficiency; and (6) improvements in the coordination and referrals for other community resources and supports. Performance in the benchmark areas is to be assessed at three and five years following the start of program.

⁴¹ The ACA also appropriated \$750 million to the Prevention and Public Health Fund for FY2011. This line of text was removed from the provision in 2012, which did not affect the availability of FY2011 funds.

⁴² Amounts do not reflect sequestration of nonexempt nondefense mandatory spending for FY2013 through FY2027.

Each eligible entity is required to submit a report to the HHS Secretary demonstrating that it has made improvements in at least four of the six benchmark areas during the first three years that it carries out the program. The report is to be submitted within 30 days of the end of that three-year period. An eligible entity must submit, as part of its grant application to HHS, the quantifiable and measurable benchmarks it has established to demonstrate that the program contributes to improvements for eligible families in the six areas.⁴³

If an eligible entity fails to demonstrate improvements in four of the six benchmark areas within the first three years of program implementation, it must develop and implement a plan to make improvements in each of the applicable benchmark areas, subject to approval by the HHS Secretary.

The improvement plan must include provisions for the HHS Secretary to monitor the plan's implementation and conduct continued oversight of the program, including by regular reports submitted by the eligible entity.

The Secretary must provide technical assistance—directly or through grants, contracts, or cooperative agreements—to the eligible entity in developing and implementing the plan to address improvements after the initial three years. The HHS Secretary must convene an advisory panel made up of staff from HHS and the Department of Education to make recommendations about this technical assistance.

The HHS Secretary must terminate an eligible entity's MIECHV funding if, after a period of time specified by the Secretary, the eligible entity has not made improvements in at least four of the benchmark areas during the first three years of the program's implementation; or if the Secretary determines that the eligible entity has failed to submit the required report on performance in the benchmark areas after that initial three-year period. The Secretary may include any unexpended grant funds in grants made to nonprofit organizations that operate home visiting programs in states that had not (as of the beginning of FY2012) applied or been approved for a MIECHV grant.

Provision

Section 50602 amends SSA Section 511(d) to direct eligible entities to continue tracking and reporting, subject to the approval of the HHS Secretary, information demonstrating that the program results in improvements for participating families in at least four of the benchmark areas. These four or more benchmark areas include those that the service delivery model(s), as selected by the eligible entity, intends to improve. Specifically, the improvements are to be based on a comparison between enrolled families and eligible families who do not receive services under a home visiting program. Eligible entities are required to track the benchmarks and report on them within 30 days after the end of FY2020 and every three subsequent years. In addition, Section 50602 amends SSA Section 511(e)(f) to require eligible entities to continue submitting this information as part of their grant application; however, the information must pertain to the four or more benchmark areas that the service delivery model(s) intends to improve.

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 benchmark areas (subject to approval by the HHS Secretary) applicable to the service delivery model(s) selected by the entity. The improvement plan must include the same provisions that have been required under preexisting law. The Secretary is required to continue providing technical assistance, in the same

⁴³ Most eligible entities had to submit the report by October 30, 2014, to show that improvements were made between FY2012, when the program was fully implemented, and FY2014, the third year of implementation.

manner as in preexisting law, to the eligible entity in developing and implementing the improvement plan. (Note: The provision does not address the ongoing role of the advisory panel.)

HHS may terminate funding for an eligible entity that (1) does not continue to demonstrate ongoing improvements in at least four of the benchmark areas (after a period of time specified by the Secretary) that the service model(s), as selected by the eligible entity, intends to improve, or (2) has failed to submit the required reporting to the HHS Secretary on improvements made in the benchmark areas.

Section 50603: Reviewing Statewide Needs to Target Resources

Background

As a condition of receiving funds under the MCH Services Block Grant for FY2011, states were required to conduct a statewide needs assessment for the MIECHV program. The statewide needs assessment has three purposes, as outlined in the law:

- Identify communities with concentrations of premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high school dropouts; substance abuse; unemployment; or child maltreatment.
- Determine the quality and capacity of existing programs or initiatives for early childhood home visitation in the jurisdiction, including the number and types of individuals and families receiving services under such programs or initiatives; gaps in early childhood home visitation in the jurisdiction; and the extent to which such programs and initiatives are meeting the needs of eligible families.
- Determine the state's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

The needs assessment was to be separate from the statewide needs assessment required under the MCH Services Block Grant.

Provision

Section 50603 amends SSA Section 511(b)(1) to direct eligible entities to conduct another statewide needs assessment as a condition of receiving funds under the MCH Services Block Grant. The assessment must be coordinated with the statewide needs assessment required under the Maternal and Child Health Services Block Grant, but may be conducted separately. The assessment must be reviewed and updated by the eligible entity no later than October 1, 2020.

Section 50604: Improving the Likelihood of Success in High-Risk Communities

Background

Eligible entities must give priority for providing home visiting services to specified high-risk populations, including eligible families that (1) reside in communities in need of home visiting services, as identified in the statewide needs assessment; (2) are low-income; (3) include pregnant women under age 21; (4) have a history of child abuse or neglect or have had interactions with

child welfare services; (5) have a history of substance abuse or need substance abuse treatment; (6) have users of tobacco products in the home; (7) have children with low student achievement; (8) have children with developmental delays or disabilities; or (9) include individuals who are, or were, serving in the Armed Forces, including families with members who have multiple deployments outside of the United States.

Provision

Section 50604 amends SSA Section(d)(4)(A) to allow eligible entities to take into account additional factors—staffing, community resource,⁴⁴ and other requirements of the service delivery model(s)—that are necessary for the model to operate and demonstrate improvements for high-risk families identified in the needs assessment.

Section 50605: Option to Fund Evidence-Based Home Visiting on a Pay-for-Outcome Basis

Background

SSA Section 511 did not previously address a pay-for-outcomes initiative.

Provision

Section 50605 amends SSA Section 511(c) to enable eligible entities to use up to 25% of its MIECHV funding for outcomes or success-based payments related to a pay-for-outcomes initiative that satisfies the requirements for providing evidence-based home visiting services.

“Pay for outcome initiative” is defined as a performance-based grant, contract, or cooperative agreement awarded by a public entity in which a commitment is made to pay for improved outcomes that result in social benefit and direct cost savings or cost avoidance to the public sector. Such an initiative is to include

- a feasibility study that describes how the proposed intervention is based on evidence of effectiveness;
- a rigorous third-party evaluation that uses experimental or quasi-experimental design, or other research methodologies, that allow for the strongest possible causal inferences to determine whether the initiative has met its proposed outcomes;
- an annual, publicly available report on the progress of the initiative;
- a requirement that payments are made to the recipient of a grant, contract, or cooperative agreement only when agreed upon outcomes are achieved, except that this requirement does not apply to payments for the third-party evaluation.

Funding for pay-for-outcomes initiatives could be expended by the eligible entity for up to 10 years after the funds are made available. (With the exception of this provision, eligible entities have two fiscal years to expend MIECHV funds.)

⁴⁴ The law states “community resource” as opposed to “community resources.”

Section 50606: Data Exchange Standards for Improved Interoperability

Background

SSA Section 511 did not previously address data exchange standards.

Provision

Section 50606 amends SSA Section 511(h) to require the head of the department or agency responsible for the MIECHV program (i.e., HRSA and ACF), per SSA Section 511(h), 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. These standards are to be developed in consultation with an interagency workgroup established by the Office of Management and Budget (OMB) and considering the perspectives of states. To the extent practicable, the data exchange standards must be nonproprietary and interoperable and incorporate standards developed and maintained by three groups of stakeholders: (1) an international voluntary consensus standards body, as defined by OMB; (2) intergovernmental partnerships, such as the National Information Exchange Model; and (3) federal entities with authority over contracting and financial assistance.

Also in consultation with OMB, and considering the perspectives of state governments, the provision directs HRSA and ACF to designate data exchange standards to govern federal reporting and data exchanges required under federal law. To the extent practicable, the data exchange standards must (1) incorporate features that are widely accepted, nonproprietary, and searchable, and are in computer-readable format (such as the eXtensible Markup Language); (2) be consistent with and implement applicable accounting principles; (3) be implemented in a manner that is cost-effective and improves program efficiency and effectiveness; and (4) be capable of being continually upgraded as necessary.

The provision includes a rule of construction to specify that changes in existing data standards for federal reporting do not require a change to standards that HHS finds to be effective and efficient. The provision goes into effect two years after the law's enactment.

Section 50607: Allocation of Funds

Background

Prior law did not address how funds are to be allocated under the MIECHV program. In practice, HHS distributes MIECHV funds by both formula and competitive grants to states and other jurisdictions. The formula awards are based, in part, on relative rates of poverty among children under age five. Poverty data are not applied for the territories because of a general lack of federal poverty data for those jurisdictions; however, federal poverty data are available for Puerto Rico. The territories have received \$1 million each in formula funds annually.

Provision

Section 50607 amends SSA Section 511(j) to direct 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.

Medicaid

Section 53101: Modifying Reductions in Medicaid DSH Allotments

Background

SSA Section 1923 requires states to make Medicaid DSH payments to hospitals treating large numbers of low-income patients.⁴⁵ This provision was intended to recognize the disadvantaged financial situation of those hospitals because low-income patients are more likely to be uninsured or Medicaid enrollees. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates generally are lower than the rates paid by Medicare and private insurance.

Whereas most federal Medicaid funding is provided on an open-ended basis, federal Medicaid DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments. Each state's Medicaid DSH allotment increases annually by the percentage change in the Consumer Price Index for All Urban Consumers for the prior fiscal year.

The ACA reduced the number of uninsured individuals in the United States through its health insurance coverage provisions. Built on the premise that with fewer uninsured individuals there should be less need for Medicaid DSH payments, the ACA included a provision directing the HHS Secretary to make aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020. However, multiple subsequent laws amended the reductions. Under prior law, the aggregate reductions to the Medicaid DSH allotments totaled \$43 billion and were to affect allotments for FY2018 through FY2025. After FY2025, allotments would have been calculated as though the reductions never occurred, which means the allotments would have to include the inflation adjustments for the years during the reductions.

Provision

Section 53101 further amends the Medicaid DSH reductions under SSA Section 1923(f)(7) by eliminating the reductions for FY2018 and FY2019 and increasing the annual reduction amounts for FY2021 through FY2023. The aggregate reduction amounts increase from \$43.0 billion to \$44.0 billion. Specifically, under this provision, the annual aggregate reductions to the Medicaid DSH allotments are \$4.0 billion in FY2020 and \$8.0 billion for each year from FY2021 through FY2025. In FY2026, states' DSH allotments will be calculated as though the reductions never occurred, with the annual inflation adjustments for FY2020 through FY2025.

Section 53102: Third-Party Liability in Medicaid and CHIP

Background

Under SSA Section 1902(a)(25), Medicaid generally serves as the payer of last resort. This means that Medicaid will pay for services only to the extent that third parties are not liable. This principle is referred to as *third-party liability* (TPL).

States must collect information concerning TPL at the time of Medicaid eligibility determinations and redeterminations. When an enrollee is entitled to payment by a third party for an item or

⁴⁵ For more information about Medicaid disproportionate share hospital (DSH) payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

service but Medicaid has already paid, the enrollee is considered to have assigned his or her claim to payment to the state.

Under SSA Section 1902(a)(25)(I)(i), states must, through state law, require health insurers to provide to the state, upon request, coverage information concerning Medicaid enrollees or Medicaid-eligible individuals. At state option, the same requirements can be imposed on health insurers with respect to CHIP enrollees or CHIP-eligible individuals.

Under the federal Medicaid regulations, states must require providers to bill liable third parties before billing Medicaid.⁴⁶ (This requirement is referred to as *cost avoidance*.) SSA Sections 1902(a)(25)(E) and (F) provide for exceptions to the cost-avoidance rule. Specifically, for (1) preventive pediatric services and prenatal services (subparagraph (E)) and (2) services rendered to individuals on whose behalf child support enforcement is being carried out (subparagraph (F)), states are required to pay providers' claims under standard claims payment rules and then seek reimbursement from liable third parties, rather than withholding payment until the third party's liability has been determined.

Section 202 of the Bipartisan Budget Act of 2013 (BBA 13; P.L. 113-67, Division A) made two sets of amendments to Medicaid TPL rules under SSA Section 1902(a)(25).

First, BBA 13 Section 202(a) limited the exceptions to the Medicaid TPL requirement of cost avoidance in SSA Section 1902(a)(25)(E) and (F). For preventive pediatric and prenatal services, states may choose to defer payment to providers until 90 days after the date the provider submitted a claim to the third party relating to the services. However, for services to children on whose behalf child support enforcement is being carried out, states must pay a claim under normal claims payment rules if the third party has not paid the provider within 90 days after the provider submitted a claim to the third party, and states may choose to limit the payment delay to 30 days if they determine it is cost-effective and necessary to ensure access to care.

Second, BBA 13 Section 202(b) amended the SSA to enable states to recover all portions of TPL payments, such as judgments and liability settlements, received by Medicaid enrollees and clarified that states may impose liens against Medicaid enrollees' assets obtained as part of a judgment or liability settlement.

The BBA 13 provisions, as amended by PAMA and MACRA, took effect on October 1, 2017.

Provision

Section 53102 makes various changes to the TPL rules in SSA Section 1902(a)(25).

Section 53102(a) amends SSA Section 1902(a)(25)(E), effective upon enactment, so that the cost-avoidance exception described in that subparagraph applies only to preventive pediatric services and not to prenatal services.

Section 53102(b) repeals and delays the TPL changes made by BBA 13. The amendments made by BBA 13 Section 202(b), relating to states' recovery of TPL payments to Medicaid beneficiaries, which took effect on October 1, 2017, are repealed retroactively effective September 30, 2017, so that it is as if they never took effect. The effective date of the amendments made by BBA 13 Section 202(a) to SSA Section 1902(a)(25)(E) and (F), narrowing the TPL cost avoidance exceptions, is delayed by two years, so that those provisions will take effect on October 1, 2019. The repeal and amendment of the BBA 13 Section 202 provisions take

⁴⁶ 42 C.F.R. §433.139(b).

effect retroactively, as if enacted on September 30, 2017, and apply with respect to any open claims, including claims pending, generated, or filed, after that date.

Section 53102(c) requires the Comptroller General of the United States to submit a report to the House Committee on Energy and Commerce and the Senate Finance Committee not later than 18 months after the date of enactment of BBA 2018 addressing the TPL changes involved in the removal of the cost-avoidance exception for prenatal services at SSA Section 1902(a)(25)(E) (Section 53102(a)(1)) and the delay in the effective date of the BBA 13 amendments relating to the cost avoidance exceptions at SSA Section 1902(a)(25)(E) and (F) (Section 53102(b)(2)). The report should examine (1) the actual or potential impact of the provisions on access to prenatal services, preventive pediatric services, and services to children on whose behalf while support enforcement is being carried out; and (2) the actual or potential impact on providers of payment delays resulting from the provisions.

Section 53102(d) amends SSA Section 2107(e) to list the TPL requirements at SSA Section 1902(a)(25) as a Medicaid provision binding on the CHIP program. In addition, subsection (d) amends SSA Section 1902(a)(25)(I)(i) to make it mandatory (rather than optional) for states to require health insurers to respond to coverage queries concerning CHIP enrollees and CHIP-eligible individuals.

Section 53103: Treatment of Lottery Winnings and Other Lump-Sum Income for Purposes of Income Eligibility under Medicaid

Background

The ACA created Section 36B of the Internal Revenue Code (IRC) to provide premium assistance tax credits for individuals to purchase coverage through the health insurance exchanges, among other purposes. Section 36B includes a definition of household income, based on MAGI. Section 36B's definition of MAGI is used to determine eligibility for various federal health programs, including Medicaid. As of January 1, 2014, MAGI rules are used in determining eligibility for most of Medicaid's nonelderly populations, including the ACA Medicaid expansion.

Medicaid's MAGI income-counting rule is set forth in law and regulation. Under the Medicaid MAGI counting rules, the state looks at each individual's MAGI, deducts 5%, which the law provides as a standard disregard for individuals at the highest income limit for coverage, and compares that income to the income standards set by the state in coordination with CMS.

For Medicaid, MAGI is defined as the IRC's adjusted gross income (AGI, which reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments) increased by certain types of income (e.g., tax-exempt interest income received or accrued during the taxable year and the nontaxable portion of Social Security benefits). In addition, under Medicaid regulations, certain types of income are subtracted (e.g., certain scholarships and fellowships) to arrive at MAGI. Also under Medicaid regulations, irregular income received as a lump sum (e.g., state income tax refund, lottery or gambling winnings, one-time gifts or inheritances) is counted as income only in the month received. In addition to specifying the types of household income that must be considered during eligibility determinations, the regulations also define "household." The income of any person defined as a part of an individual's "household" must be counted when determining that individual's income level for purposes of a Medicaid eligibility determination.

Medicaid program regulations make a distinction with regard to the budget period when determining income eligibility for applicants and new enrollees as compared to eligibility

redeterminations for current enrollees. Specifically, income eligibility for applicants and new enrollees is based on current monthly household income. When redetermining eligibility for current Medicaid enrollees, states are permitted to use current monthly income and family size, or projected annual income and family size for the remaining months of the calendar year. For states that choose the latter measure when redetermining eligibility, Medicaid requires the applicant to predict income and household size for the remaining months of the calendar year.

Provision

Section 53103 amends SSA Section 1902(a)(17) to require 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 MAGI for each such individual. Such income is not counted as household income when determining Medicaid eligibility for other members of the individual’s household.

Winnings and/or income in an amount less than \$80,000 are considered in the month that such winnings and/or income are received. Amounts greater than or equal to \$80,000 but less than \$90,000 are prorated over a period of two months. Amounts greater than or equal to \$90,000 but less than \$100,000 are prorated over a period of three months. For purpose of prorating winnings and/or income in amounts greater than or equal to \$100,000, one additional month is added for each increment of \$10,000 received, not to exceed 120 months (or 10 years) for winnings and/or income of \$1,260,000 or more. Winnings and/or income greater than or equal to \$80,000 are counted in equal monthly installments over the applicable time period.

The provision establishes a state option for a hardship exemption for individuals for whom the denial of Medicaid eligibility based on such income would cause an undue medical or financial hardship as determined by criteria established by the HHS Secretary. States are required to inform individuals in advance of their loss of Medicaid eligibility of their option to enroll in a qualified health plan offered through the health insurance exchange during a special enrollment period (due to the loss of Medicaid or CHIP coverage) and to provide technical assistance to assist such individuals in enrolling in such coverage. States are also required to inform each individual of the date that such individual is permitted to reapply for Medicaid.

The provision defines “qualified lottery winnings” as winnings (including amounts awarded as a lump sum payment) from a state-conducted sweepstakes or lottery, or a lottery operated by a multistate or multijurisdictional lottery association. The provision defines “qualified lump sum” income as income received as a lump sum from monetary winnings from gambling (as defined by the HHS Secretary and including monetary winnings from gambling activities described in section 1955(b)(4) of title 18 of the *United States Code*). The provision specifies that states may recover lottery winnings awarded to the individual to pay for Medicaid medical assistance furnished to the individual.

Section 53104: Rebate Obligation with Respect to Line Extension Drugs

Background

Prescription drugs are an optional benefit for states, but all states cover outpatient drugs for Medicaid beneficiaries. For states to receive matching federal medical assistance payments for purchasing covered outpatient drugs for Medicaid beneficiaries, a drug’s manufacturer must have entered into a rebate agreement with the HHS Secretary.

The Medicaid Drug Rebate Program (MDRP) agreement obligates drug manufacturers to provide a discount to state Medicaid programs on covered outpatient drug purchases. In exchange, by voluntarily agreeing to the MDRP terms, drug manufacturers are guaranteed that Medicare and Medicaid will cover most of their drug products that are approved for marketing by the Food and Drug Administration (FDA). In general, Medicaid-covered outpatient drugs include FDA-approved drugs requiring a prescription, including biologic drugs and insulin, but not vaccines or when drug payment is included as part of another service. FDA considers biologic drugs to be those derived from natural sources (human, animal, and microorganism) that are used to treat diseases and medical conditions. In this discussion, references to covered outpatient drugs also apply to biological drugs.

Medicaid rebates on covered drugs include a basic rebate and an additional rebate, which together comprise the statutory total rebate. The basic rebate is the greater of either (1) the difference between the best price and the drug's Average Manufacturer Price (AMP) or (2) a specified percentage of the drug's AMP, which varies depending on the type of drug. The additional rebate owed for each drug is the amount the manufacturer increased the drug's AMP above the product's inflation-rate-adjusted AMP since the product was introduced. As the manufacturer increases the drug's AMP above the inflation rate, it owes a larger additional rebate.

Under previous law, modifications to existing drug products, such as new doses or formulations, generally were considered new products for determining drug manufacturers' Medicaid rebate obligations. As a result, drug manufacturers could incur a lower additional rebate when they introduced a new line-extension formulation that was based on an existing product. For example, under previous law, drug manufacturers often introduced extended-release formulations of existing products that were considered new products. While line-extension formulations generally are introduced at a higher price than the reference product from which they were derived, the additional rebate is calculated from the most recent date of introduction of the line-extension rather than from the date the reference product was introduced. As a result, drug manufacturers often owe an additional rebate on the reference product, but owe little or no additional rebate on the line-extension drug introduced at a later date.

Drug manufacturers may reduce their Medicaid rebate obligations as sales of line-extension drugs quickly exceed sales of their reference products due to the more favorable characteristics of the line extensions, such as extended release formulations, that are preferred by consumers over multiple-dose formulations.

Provision

Section 53104 amends SSA Section 1927(c)(2)(C) to clarify drug manufacturers' Medicaid rebate obligations on oral solid dose innovator single and multiple source line-extension drugs. Under Section 53104, drug manufacturers owe the greater of either (1) the statutory total Medicaid rebate—basic rebate plus additional rebate—for the line-extension drug or, (2) the statutory total rebate for the product from which the line extension was developed. Section 53104 also removes a reference in statute to extended-release formulations as an example of line-extension products. Section 53104 is effective for rebate periods beginning on or after October 1, 2018.

Section 53105: Medicaid Improvement Fund

Background

The HHS Secretary was required to establish the Medicaid Improvement Fund and use funds to improve the management of the Medicaid program, including oversight of contracts and

contractors and evaluation of demonstration projects. Appropriations for the Medicaid Improvement Fund have been modified repeatedly, but the funding has not yet been obligated for the purposes described in the authorizing legislation. For FY2021 and thereafter, Congress appropriated \$5 million for the Medicaid Improvement Fund to be available for expenditures. In addition, Congress appropriated \$980 million to the Medicaid Improvement Fund for the Secretary to fund state activities related to mechanized claims processing systems beginning on or after FY2023. The Secretary is permitted to obligate Medicaid Improvement Fund resources in advance of future appropriations as long as the total amount obligated does not exceed the amount available to the fund.

Provision

Section 53105 amends SSA Section 1941(b) to rescind the \$5 million appropriated for the Medicaid Improvement Fund for FY2021 and thereafter. Section 53105 also rescinds the \$980 million from the Medicaid Improvement Fund appropriated for the Secretary to use to fund state activities related to mechanized claims systems for FY2023 and thereafter.

Appendix A. Acronyms Used in the Report

ACA	Patient Protection and Affordable Care Act (P.L. 111-148, as amended)
ACF	Administration for Children and Families
AMP	Average Manufacturer Price
AGI	Adjusted Gross Income
BBA97	Balanced Budget Act of 1997 (P.L. 105-133)
BBA 13	Bipartisan Budget Act of 2013 (P.L. 113-67)
BBA 2018	Balanced Budget Act of 2018 (P.L. 115-123)
CBO	Congressional Budget Office
CHC	Community Health Center
CHCF	Community Health Center Fund
CHIP	State Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare & Medicaid Services
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005 (P.L. 109-171)
DSH	Disproportionate Share Hospital
E-FMAP	Enhanced Federal Medical Assistance Percentage
EHR	Electronic Health Record
FDA	Food and Drug Administration
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FYSB	Family and Youth Services Bureau
GME	Graduate Medical Education
HHS	Health and Human Services
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRSA	Health Resources and Services Administration
HPOG	Health Profession Opportunity Grant
HPSA	Health Professional Shortage Area
IHS	Indian Health Service
IOM	Institute of Medicine (now National Academy of Medicine)
IRC	Internal Revenue Code
MACPAC	Medicaid and CHIP Payment Access Commission
MACRA	Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10)
MAGI	Modified Adjusted Gross Income
MCH	Maternal and Child Health
MDRP	Medicaid Drug Rebate Program
MIECHV	Maternal, Infant, and Early Childhood Home Visiting
MIPPA	Medicare Improvements for Patients and Providers Act of 2008

MOE	Maintenance of Effort
MUA	Medically Underserved Area
NHSC	National Health Service Corps
NIH	National Institutes of Health
OMB	Office of Management and Budget
PAMA	Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93)
PHSA	Public Health Service Act
PMI	Precision Medicine Initiative
PQMP	Pediatric Quality Measures Program
PPHF	Public Health and Prevention Fund
PREP	Personal Responsibility Education Program
PREIS	Personal Responsibility Education Program Innovative Strategies
SSA	Social Security Act
STI	Sexually Transmitted Infection
THCGME	Teaching Health Center Graduate Medical Education Program
TPL	Third Party Liability

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