DIVISION E—HEALTH AND HUMAN SERVICES EXTENDERS

SEC. 50100. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This division may be cited as the “Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act”

(b) TABLE OF CONTENTS.—The table of contents for this division is as follows:

DIVISION E—HEALTH AND HUMAN SERVICES EXTENDERS

Sec. 50100. Short title; table of contents.

TITLE I—CHIP

Sec. 50101. Funding extension of the Children’s Health Insurance Program through fiscal year 2027.
Sec. 50102. Extension of pediatric quality measures program.
Sec. 50103. Extension of outreach and enrollment program.

TITLE II—MEDICARE EXTENDERS

Sec. 50201. Extension of work GPCI floor.
Sec. 50202. Repeal of Medicare payment cap for therapy services; limitation to ensure appropriate therapy.
Sec. 50203. Medicare ambulance services.
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Sec. 50206. Extension of funding for quality measure endorsement, input, and selection; reporting requirements.
Sec. 50207. Extension of funding outreach and assistance for low-income programs; State health insurance assistance program reporting requirements.
Sec. 50208. Extension of home health rural add-on.

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Sec. 50301. Extending the Independence at Home Demonstration Program.
Sec. 50302. Expanding access to home dialysis therapy.
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Sec. 50321. Adapting benefits to meet the needs of chronically ill Medicare Advantage enrollees.
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Sec. 50401. Home infusion therapy services temporary transitional payment.
Sec. 50402. Orthotist’s and prosthetist’s clinical notes as part of the patient’s medical record.
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Sec. 50404. Modernizing the application of the Stark rule under Medicare.

Subtitle B—Additional Medicare Provisions

Sec. 50411. Making permanent the removal of the rental cap for durable medical equipment under Medicare with respect to speech generating devices.
Sec. 50412. Increased civil and criminal penalties and increased sentences for Federal health care program fraud and abuse.

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Sec. 53112. Preventing the artificial inflation of star ratings after the consolidation of Medicare Advantage plans offered by the same organization.
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[TITLE I—CHIP]

[SEC. 50101. FUNDING EXTENSION OF THE CHILDREN’S HEALTH INSURANCE PROGRAM THROUGH FISCAL YEAR 2027.]

(a) IN GENERAL.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)), as amended by section 3002(a) of the HEALTHY KIDS Act (division C of Public Law 115–120), is amended—

[(1) in paragraph (25), by striking “; and” and inserting a semicolon;]

[(2) in paragraph (26), by striking the period at the end and inserting a semicolon; and]

[(3) by adding at the end the following new paragraphs:]

[(“(27) for each of fiscal years 2024 through 2026, such sums as are necessary to fund allotments to States under subsections (e) and (m); and]

[(“(28) for fiscal year 2027, for purposes of making two semi-annual allotments—]

[(“A) $7,650,000,000 for the period beginning on October 1, 2026, and ending on March 31, 2027; and]
“(B) $7,650,000,000 for the period beginning on April 1, 2027, and ending on September 30, 2027.”.

(b) ALLOTMENTS.—

(1) IN GENERAL.—Section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)), as amended by section 3002(b) of the HEALTHY KIDS Act (division C of Public Law 115–120), is amended—

(A) in paragraph (2)(B)—

(i) in the matter preceding clause (i), by striking “(25)” and inserting “(27)”;

(ii) in clause (i), by striking “and 2023” and inserting “, 2023, and 2027”; and

(iii) in clause (ii)(I), by striking “(or, in the case of fiscal year 2018, under paragraph (4))” and inserting “(or, in the case of fiscal year 2018 or 2024, under paragraph (4) or (10), respectively)”;

(B) in paragraph (5)—

(i) by striking “or (10)” and inserting “(10), or (11)”; and

(ii) by striking “or 2023,” and inserting “2023, or 2027,”;
[(C) in paragraph (7)—]

[(i) in subparagraph (A), by striking “2023” and inserting “2027,”; and]

[(ii) in the matter following subparagraph (B), by striking “or fiscal year 2022” and inserting “fiscal year 2022, fiscal year 2024, or fiscal year 2026”;

[(D) in paragraph (9)—]

[(i) by striking “or (10)” and inserting “(10), or (11)”; and]

[(ii) by striking “or 2023,” and inserting “2023, or 2027,”; and]

[(E) by adding at the end the following:]

"(11) FOR FISCAL YEAR 2027.—"

"(A) FIRST HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (28) of subsection (a) for the semiannual period described in such subparagraph, increased by the amount of the appropriation for such period under section 50101(b)(2) of the Advancing Chronic Care, Extenders, and Social Services Act, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and terri-
tory) for such semi-annual period in an amount
equal to the first half ratio (described in sub-
paragraph (D)) of the amount described in sub-
paragraph (C).

[("(B) SECOND HALF.—Subject to para-
graphs (5) and (7), from the amount made
available under subparagraph (B) of paragraph
(28) of subsection (a) for the semi-annual pe-
riod described in such subparagraph, the Sec-
retary shall compute a State allotment for each
State (including the District of Columbia and
each commonwealth and territory) for such
semi-annual period in an amount equal to the
amount made available under such subpara-
graph, multiplied by the ratio of—"

[("(i) the amount of the allotment to
such State under subparagraph (A); to"

[("(ii) the total of the amount of all of
the allotments made available under such
subparagraph."

[("(C) FULL YEAR AMOUNT BASED ON
REBASED AMOUNT.—The amount described in
this subparagraph for a State is equal to the
Federal payments to the State that are attrib-
utable to (and countable towards) the total
amount of allotments available under this section to the State in fiscal year 2026 (including payments made to the State under subsection (n) for fiscal year 2026 as well as amounts redistributed to the State in fiscal year 2026), multiplied by the allotment increase factor under paragraph (6) for fiscal year 2027.]

[“(D) FIRST HALF RATIO.—The first half ratio described in this subparagraph is the ratio of—]

[“(i) the sum of—]

[“(I) the amount made available under subsection (a)(28)(A); and]

[“(II) the amount of the appropriation for such period under section 50101(b)(2) of the Advancing Chronic Care, Extenders, and Social Services Act; to]

[“(ii) the sum of—]

[“(I) the amount described in clause (i); and]

[“(II) the amount made available under subsection (a)(28)(B).”].]

[(2) ONE-TIME APPROPRIATION FOR FISCAL YEAR 2027.—There is appropriated to the Secretary
of Health and Human Services, out of any money in the Treasury not otherwise appropriated, such sums as are necessary to fund allotments to States under subsections (e) and (m) of section 2104 of the Social Security Act (42 U.S.C. 1397dd) for fiscal year 2027, taking into account the full year amounts calculated for States under paragraph (11)(C) of subsection (m) of such section (as added by paragraph (1)) and the amounts appropriated under subparagraphs (A) and (B) of subsection (a)(28) of such section (as added by subsection (a)). Such amount shall accompany the allotment made for the period beginning on October 1, 2026, and ending on March 31, 2027, under paragraph (28)(A) of section 2104(a) of such Act (42 U.S.C. 1397dd(a)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (11) of section 2104(m) of such Act for the first 6 months of fiscal year 2027 in the same manner as allotments are provided under subsection (a)(28)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(28)(A).

[(c) EXTENSION OF THE CHILD ENROLLMENT CON-}

TINGENCY FUND.—Section 2104(n) of the Social Security
Act (42 U.S.C. 1397dd(n)), as amended by section 3002(c) of the HEALTHY KIDS Act (division C of Public Law 115–120), is amended—

[(1) in paragraph (2)—]

[(A) in subparagraph (A)(ii)—]

[(i) by striking “and 2018 through 2022” and inserting “2018 through 2022, and 2024 through 2026”; and]

[(ii) by striking “and 2023” and inserting “2023, and 2027”; and]

[(B) in subparagraph (B)—]

[(i) by striking “and 2018 through 2022” and inserting “2018 through 2022, and 2024 through 2026”; and]

[(ii) by striking “and 2023” and inserting “2023, and 2027”; and]

[(2) in paragraph (3)(A), in the matter preceding clause (i)—]

[(A) by striking “or in any of fiscal years 2018 through 2022” and inserting “fiscal years 2018 through 2022, or fiscal years 2024 through 2026”; and]

[(B) by striking “or 2023” and inserting “2023, or 2027”.]
(d) Extension of Qualifying States Option.—Section 2105(g)(4) of the Social Security Act (42 U.S.C. 1397ee(g)(4)), as amended by section 3002(d) of the HEALTHY KIDS Act (division C of Public Law 115–120), is amended—

(1) in the paragraph heading, by striking “THROUGH 2023” and inserting “THROUGH 2027”;

and

(2) in subparagraph (A), by striking “2023” and inserting “2027”.

(e) Extension of Express Lane Eligibility Option.—Section 1902(e)(13)(I) of the Social Security Act (42 U.S.C. 1396a(e)(13)(I)), as amended by section 3002(e) of the HEALTHY KIDS Act (division C of Public Law 115–120), is amended by striking “2023” and inserting “2027”.

(f) Assurance of Eligibility Standard for Children and Families.—

(1) In general.—Section 2105(d)(3) of the Social Security Act (42 U.S.C. 1397ee(d)(3)), as amended by section 3002(f)(1) of the HEALTHY KIDS Act (division C of Public Law 115–120), is amended—
[(A) in the paragraph heading, by striking “THROUGH SEPTEMBER 30, 2023” and inserting “THROUGH SEPTEMBER 30, 2027”; and]

[(B) in subparagraph (A), in the matter preceding clause (i), by striking “2023” each place it appears and inserting “2027”.]

[(2) CONFORMING AMENDMENTS.—Section 1902(gg)(2) of the Social Security Act (42 U.S.C. 1396a(gg)(2)), as amended by section 3002(f)(2) of the HEALTHY KIDS Act (division C of Public Law 115–120), is amended—]

[(A) in the paragraph heading, by striking “THROUGH SEPTEMBER 30, 2023” and inserting “THROUGH SEPTEMBER 30, 2027”; and]

[(B) by striking “2023,” each place it appears and inserting “2027”.]

SEC. 50102. EXTENSION OF PEDIATRIC QUALITY MEASURES PROGRAM.

[(a) IN GENERAL.—Section 1139A(i)(1) of the Social Security Act (42 U.S.C. 1320b–9a(i)(1)), as amended by section 3003(b) of the HEALTHY KIDS Act (division C of Public Law 115–120), is amended—]

[(1) in subparagraph (B), by striking “; and” and inserting a semicolon;]
(2) in subparagraph (C), by striking the period at the end and inserting “; and”;

(3) by adding at the end the following new subparagraph:

“(D) for the period of fiscal years 2024 through 2027, $60,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g)).”.

(b) MAKING REPORTING MANDATORY.—Section 1139A of the Social Security Act (42 U.S.C. 1320b–9a) is amended—

(1) in subsection (a)—

(A) in the heading for paragraph (4), by inserting “AND MANDATORY REPORTING” after “REPORTING”;

(B) in paragraph (4)—

(i) by striking “Not later than” and inserting the following:

“(A) VOLUNTARY REPORTING.—Not later than”; and

(ii) by adding at the end the following:

“(B) MANDATORY REPORTING.—Beginning with the annual State report on fiscal year 2024 required under subsection (c)(1), the Sec-
retary shall require States to use the initial core measurement set and any updates or changes to that set to report information regarding the quality of pediatric health care under titles XIX and XXI using the standardized format for reporting information and procedures developed under subparagraph (A).’’; and]

(C) in paragraph (6)(B), by inserting “and, beginning with the report required on January 1, 2025, and for each annual report thereafter, the status of mandatory reporting by States under titles XIX and XXI, utilizing the initial core quality measurement set and any updates or changes to that set” before the semicolon; and]

(2) in subsection (c)(1)(A), by inserting “and, beginning with the annual report on fiscal year 2024, all of the core measures described in subsection (a) and any updates or changes to those measures” before the semicolon.]

[SEC. 50103. EXTENSION OF OUTREACH AND ENROLLMENT PROGRAM.

(a) In General.—Section 2113 of the Social Security Act (42 U.S.C. 1397mm), as amended by section
3004(a) of the HEALTHY KIDS Act (division C of Public Law 115–120), is amended—

[(1) in subsection (a)(1), by striking “2023” and inserting “2027”; and]

[(2) in subsection (g)—]

[(A) by striking “and $120,000,000” and inserting “, $120,000,000”; and]

[(B) by inserting “, and $48,000,000 for the period of fiscal years 2024 through 2027” after “2023”.]

[(b) ADDITIONAL RESERVED FUNDS.—Section 2113(a) of the Social Security Act (42 U.S.C. 1397mm(a)) is amended—]

[(1) in paragraph (1), by striking “paragraph (2)” and inserting “paragraphs (2) and (3)”]; and]

[(2) by adding at the end the following new paragraph:]

“(3) TEN PERCENT SET ASIDE FOR EVALUATING AND PROVIDING TECHNICAL ASSISTANCE TO GRANTEES.—For the period of fiscal years 2024 through 2027, an amount equal to 10 percent of such amounts shall be used by the Secretary for the purpose of evaluating and providing technical assistance to eligible entities awarded grants under this section.”.]
(c) Use of Reserved Funds for National Enrollment and Retention Strategies.—Section 2113(h) of the Social Security Act (42 U.S.C. 1397mm(h)) is amended—

(1) in paragraph (5), by striking “; and” and inserting a semicolon;

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following new paragraph:

“(6) the development of materials and toolkits and the provision of technical assistance to States regarding enrollment and retention strategies for eligible children under this title and title XIX; and”.

TITLE II—MEDICARE EXTENDERS

SEC. 50201. EXTENSION OF WORK GPCI FLOOR.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking “January 1, 2018” and inserting “January 1, 2020”.

SEC. 50202. REPEAL OF MEDICARE PAYMENT CAP FOR THERAPY SERVICES; LIMITATION TO ENSURE APPROPRIATE THERAPY.

Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—
(1) in paragraph (1)—

(A) by striking “Subject to paragraphs (4) and (5)” and inserting “(A) Subject to paragraphs (4) and (5)”;

(B) in the subparagraph (A), as inserted and designated by subparagraph (A) of this paragraph, by adding at the end the following new sentence: “The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017.”;

and

(C) by adding at the end the following new subparagraph:

“(B) With respect to services furnished during 2018 or a subsequent year, in the case of physical therapy services of the type described in section 1861(p), speech-language pathology services of the type described in such section through the application of section 1861(ll)(2), and physical therapy services and speech-language pathology services of such type which are furnished by a physician or as incident to physicians’ services, with respect to expenses incurred in any calendar year, any amount that is more than the amount specified in paragraph (2) for the year shall not be considered as incurred expenses for
purposes of subsections (a) and (b) unless the applicable requirements of paragraph (7) are met.”;

(2) in paragraph (3)—

(A) by striking “Subject to paragraphs (4) and (5)” and inserting “(A) Subject to paragraphs (4) and (5)”;

(B) in the subparagraph (A), as inserted and designated by subparagraph (A) of this paragraph, by adding at the end the following new sentence: “The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017.”;

and

(C) by adding at the end the following new subparagraph:

“(B) With respect to services furnished during 2018 or a subsequent year, in the case of occupational therapy services (of the type that are described in section 1861(p) through the operation of section 1861(g) and of such type which are furnished by a physician or as incident to physicians’ services), with respect to expenses incurred in any calendar year, any amount that is more than the amount specified in paragraph (2) for the year shall not be considered as incurred expenses for purposes of subsections (a)
and (b) unless the applicable requirements of paragraph (7) are met.”;

(3) in paragraph (5)—

(A) by redesignating subparagraph (D) as paragraph (8) and moving such paragraph to immediately follow paragraph (7), as added by paragraph (4) of this section; and

(B) in subparagraph (E)(iv), by inserting “, except as such process is applied under paragraph (7)(B)” before the period at the end; and

(4) by adding at the end the following new paragraph:

“(7) For purposes of paragraphs (1)(B) and (3)(B), with respect to services described in such paragraphs, the requirements described in this paragraph are as follows:

“(A) INCLUSION OF APPROPRIATE MODIFIER.— The claim for such services contains an appropriate modifier (such as the KX modifier described in paragraph (5)(B)) indicating that such services are medically necessary as justified by appropriate documentation in the medical record involved.

“(B) TARGETED MEDICAL REVIEW FOR CERTAIN SERVICES ABOVE THRESHOLD.—

“(i) In general.—In the case where expenses that would be incurred for such services
would exceed the threshold described in clause (ii) for the year, such services shall be subject to the process for medical review implemented under paragraph (5)(E).

“(ii) Threshold.—The threshold under this clause for—

“(I) a year before 2028, is $3,000;

“(II) 2028, is the amount specified in subclause (I) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for 2028; and

“(III) a subsequent year, is the amount specified in this clause for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year;

except that if an increase under subclause (II) or (III) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

“(iii) Application.—The threshold under clause (ii) shall be applied separately—

“(I) for physical therapy services and speech-language pathology services; and

“(II) for occupational therapy services.
“(iv) FUNDING.—For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account, of $5,000,000 for each fiscal year beginning with fiscal year 2018, to remain available until expended. Such funds may not be used by a contractor under section 1893(h) for medical reviews under this subparagraph.”.

SEC. 50203. MEDICARE AMBULANCE SERVICES.

(a) EXTENSION OF CERTAIN GROUND AMBULANCE ADD-ON PAYMENTS.—

(1) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended by striking “2018” and inserting “2023” each place it appears.

(2) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended, in the first sentence, by striking “2018” and inserting “2023”.

(b) REQUIRING GROUND AMBULANCE PROVIDERS OF SERVICES AND SUPPLIERS TO SUBMIT COST AND OTHER INFORMATION.—Section 1834(l) of the Social Security
Act (42 U.S.C. 1395m(l)) is amended by adding at the end the following new paragraph:

“(17) Submission of cost and other information.—

“(A) Development of data collection system.—The Secretary shall develop a data collection system (which may include use of a cost survey) to collect cost, revenue, utilization, and other information determined appropriate by the Secretary with respect to providers of services (in this paragraph referred to as ‘providers’) and suppliers of ground ambulance services. Such system shall be designed to collect information—

“(i) needed to evaluate the extent to which reported costs relate to payment rates under this subsection;

“(ii) on the utilization of capital equipment and ambulance capacity, including information consistent with the type of information described in section 1121(a); and

“(iii) on different types of ground ambulance services furnished in different geographic locations, including rural areas
and low population density areas described in paragraph (12).

“(B) SPECIFICATION OF DATA COLLECTION SYSTEM.—

“(i) IN GENERAL.—The Secretary shall—

“(I) not later than December 31, 2019, specify the data collection system under subparagraph (A); and

“(II) identify the providers and suppliers of ground ambulance services that would be required to submit information under such data collection system, including the representative sample described in clause (ii).

“(ii) DETERMINATION OF REPRESENTATIVE SAMPLE.—

“(I) IN GENERAL.—Not later than December 31, 2019, with respect to the data collection for the first year under such system, and for each subsequent year through 2024, the Secretary shall determine a representative sample to submit information under the data collection system.
“(II) Requirements.—The sample under subclause (I) shall be representative of the different types of providers and suppliers of ground ambulance services (such as those providers and suppliers that are part of an emergency service or part of a government organization) and the geographic locations in which ground ambulance services are furnished (such as urban, rural, and low population density areas).

“(III) Limitation.—The Secretary shall not include an individual provider or supplier of ground ambulance services in the sample under subclause (I) in 2 consecutive years, to the extent practicable.

“(C) Reporting of cost information.—For each year, a provider or supplier of ground ambulance services identified by the Secretary under subparagraph (B)(i)(II) as being required to submit information under the data collection system with respect to a period for the year shall submit to the Secretary infor-
mation specified under the system. Such information shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(D) Payment reduction for failure to report.—

“(i) In general.—Beginning January 1, 2022, subject to clause (ii), a 10 percent reduction to payments under this part shall be made for the applicable period (as defined in clause (ii)) to a provider or supplier of ground ambulance services that—

“(I) is required to submit information under the data collection system with respect to a period under subparagraph (C); and

“(II) does not sufficiently submit such information, as determined by the Secretary.

“(ii) Applicable period defined.—For purposes of clause (i), the term ‘applicable period’ means, with respect to a provider or supplier of ground ambulance services, a year specified by the
Secretary not more than 2 years after the end of the period with respect to which the Secretary has made a determination under clause (i)(II) that the provider or supplier of ground ambulance services failed to sufficiently submit information under the data collection system.

“(iii) HARDSHIP EXEMPTION.—The Secretary may exempt a provider or supplier from the payment reduction under clause (i) with respect to an applicable period in the event of significant hardship, such as a natural disaster, bankruptcy, or other similar situation that the Secretary determines interfered with the ability of the provider or supplier of ground ambulance services to submit such information in a timely manner for the specified period.

“(iv) INFORMAL REVIEW.—The Secretary shall establish a process under which a provider or supplier of ground ambulance services may seek an informal review of a determination that the provider or supplier is subject to the payment reduction under clause (i).
“(E) ONGOING DATA COLLECTION.—

“(i) REVISION OF DATA COLLECTION SYSTEM.—The Secretary may, as the Secretary determines appropriate and, if available, taking into consideration the report (or reports) under subparagraph (F), revise the data collection system under subparagraph (A).

“(ii) SUBSEQUENT DATA COLLECTION.—In order to continue to evaluate the extent to which reported costs relate to payment rates under this subsection and for other purposes the Secretary deems appropriate, the Secretary shall require providers and suppliers of ground ambulance services to submit information for years after 2024 as the Secretary determines appropriate, but in no case less often than once every 3 years.

“(F) GROUND AMBULANCE DATA COLLECTION SYSTEM STUDY.—

“(i) IN GENERAL.—Not later than March 15, 2023, and as determined necessary by the Medicare Payment Advisory Commission thereafter, such Commission
shall assess, and submit to Congress a report on, information submitted by providers and suppliers of ground ambulance services through the data collection system under subparagraph (A), the adequacy of payments for ground ambulance services under this subsection, and geographic variations in the cost of furnishing such services.

“(ii) CONTENTS.—A report under clause (i) shall contain the following:

“(I) An analysis of information submitted through the data collection system.

“(II) An analysis of any burden on providers and suppliers of ground ambulance services associated with the data collection system.

“(III) A recommendation as to whether information should continue to be submitted through such data collection system or if such system should be revised under subparagraph (E)(i).
“(IV) Other information determined appropriate by the Commission.

“(G) Public availability.—The Secretary shall post information on the results of the data collection under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services, as determined appropriate by the Secretary.

“(H) Implementation.—The Secretary shall implement this paragraph through notice and comment rulemaking.

“(I) Administration.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information required under this subsection.

“(J) Limitations on review.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the data collection system or identification of respondents under this paragraph.

“(K) Funding for implementation.—For purposes of carrying out subparagraph (A), the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of
$15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2018. Amounts transferred under this subparagraph shall remain available until expended.”.

SEC. 50204. EXTENSION OF INCREASED INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR CERTAIN LOW-VOLUME HOSPITALS.

(a) In General.—Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (B), in the matter preceding clause (i), by striking “fiscal year 2018” and inserting “fiscal year 2023”;

(2) in subparagraph (C)—

(A) in clause (i)—

(i) by striking “through 2017” the first place it appears and inserting “through 2022”; and

(ii) by striking “and has less than 800 discharges” and all that follows through the period at the end and inserting the following “and has—

“(I) with respect to each of fiscal years 2005 through 2010, less than 800 discharges during the fiscal year;
“(II) with respect to each of fiscal years 2011 through 2018, less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A during the fiscal year or portion of fiscal year;

“(III) with respect to each of fiscal years 2019 through 2022, less than 3,800 discharges during the fiscal year; and

“(IV) with respect to fiscal year 2023 and each subsequent fiscal year, less than 800 discharges during the fiscal year.”; and

(B) in clause (ii)—

(i) by striking “subparagraph (B)” and inserting “subparagraphs (B) and (D)”; and

(ii) by inserting “(except as provided in clause (i)(II) and subparagraph (D)(i))” after “regardless”; and

(3) in subparagraph (D)—

(A) by striking “through 2017” and inserting “through 2022”;
(B) by striking “hospitals with 200 or fewer” and inserting the following: “hospitals—

“(i) with respect to each of fiscal years 2011 through 2018, with 200 or fewer”;

(C) by striking the period at the end and inserting “or portion of fiscal year; and”; and

(D) by adding at the end the following new clause:

“(ii) with respect to each of fiscal years 2019 through 2022, with 500 or fewer discharges in the fiscal year to 0 percent for low-volume hospitals with greater than 3,800 discharges in the fiscal year.”.

(b) MedPAC Report on Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-volume Hospitals.—

(1) In general.—Not later than March 15, 2022, the Medicare Payment Advisory Commission shall submit to Congress a report on the extension of the increased inpatient hospital payment adjustment for certain low-volume hospitals under section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) under the provisions of, and amendments made by, this section.
(2) CONTENTS.—The report under paragraph (1) shall include an evaluation of the effects of such extension on the following:

(A) Beneficiary utilization of inpatient hospital services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(B) The financial status of hospitals with a low volume of Medicare or total inpatient admissions.

(C) Program spending under such title XVIII.

(D) Other matters relevant to evaluating the effects of such extension.

SEC. 50205. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking “October 1, 2017” and inserting “October 1, 2022”;

(2) in clause (ii)(II), by striking “October 1, 2017” and inserting “October 1, 2022”; and

(3) in clause (iv), by striking subclause (I) and inserting the following new subclause:

“(I) that is located in—
“(aa) a rural area; or

“(bb) a State with no rural area (as defined in paragraph (2)(D)) and satisfies any of the criteria in subclause (I), (II), or (III) of paragraph (8)(E)(ii),”; and

(4) by inserting after subclause (IV) the following new flush sentences:

“Subclause (I)(bb) shall apply for purposes of payment under clause (ii) only for discharges of a hospital occurring on or after the effective date of a determination of medicare-dependent small rural hospital status made by the Secretary with respect to the hospital after the date of the enactment of this sentence. For purposes of applying subclause (II) of paragraph (8)(E)(ii) under subclause (I)(bb), such subclause (II) shall be applied by inserting ‘as of January 1, 2018,’ after ‘such State’ each place it appears.”.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking “October 1, 2017” and inserting “October 1, 2022”; and
(B) in clause (iv), by striking “through fiscal year 2017” and inserting “through fiscal year 2022”.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking “through fiscal year 2017” and inserting “through fiscal year 2022”.

(c) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the “Comptroller General”) shall conduct a study on the medicare-dependent, small rural hospital program under section 1886(d) of the Social Security Act (42 U.S.C. 1395x(d)). Such study shall include an analysis of the following:

(A) The payor mix of medicare-dependent, small rural hospitals (as defined in paragraph (5)(G)(iv) of such section 1886(d)), how such mix will trend in future years (based on current trends and projections), and whether or not the requirement under subclause (IV) of such paragraph should be revised.
(B) The characteristics of medicare-dependent, small rural hospitals that meet the requirement of such subclause (IV) through the application of paragraph (a)(iii)(A) or (a)(iii)(B) of section 412.108 of title 42, Code of Federal Regulations, including Medicare inpatient and outpatient utilization, payor mix, and financial status (including Medicare and total margins), and whether or not Medicare payments for such hospitals should be revised.

(C) Such other items related to medicare-dependent, small rural hospitals as the Comptroller General determines appropriate.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.
SEC. 50206. EXTENSION OF FUNDING FOR QUALITY MEASUREMENT, INPUT, AND SELECTION; REPORTING REQUIREMENTS.

(a) Extension of Funding.—Section 1890(d)(2) of the Social Security Act (42 U.S.C. 1395aaa(d)(2)) is amended—

(1) in the first sentence—

(A) by striking “2014 and” and inserting “2014,”; and

(B) by inserting the following before the period: “, and $7,500,000 for each of fiscal years 2018 and 2019”; and

(2) by adding at the end the following new sentence: “Amounts transferred for each of fiscal years 2018 and 2019 shall be in addition to any unobligated funds transferred for a preceding fiscal year that are available under the preceding sentence.”

(b) Annual Report by Secretary to Congress.—Section 1890 of the Social Security Act (42 U.S.C. 1395aaa) is amended by adding at the end the following new subsection:

“(e) Annual Report by Secretary to Congress.—By not later than March 1 of each year (beginning with 2019), the Secretary shall submit to Congress a report containing the following:
“(1) A comprehensive plan that identifies the quality measurement needs of programs and initiatives of the Secretary and provides a strategy for using the entity with a contract under subsection (a) and any other entity the Secretary has contracted with or may contract with to perform work associated with section 1890A to help meet those needs, specifically with respect to the programs under this title and title XIX. In years after the first plan under this paragraph is submitted, the requirements of this paragraph may be met by providing an update to the plan.

“(2) The amount of funding provided under subsection (d) for purposes of carrying out this section and section 1890A that has been obligated by the Secretary, the amount of funding provided that has been expended, and the amount of funding provided that remains unobligated.

“(3) With respect to the activities described under this section or section 1890A, a description of how the funds described in paragraph (2) have been obligated or expended, including how much of that funding has been obligated or expended for work performed by the Secretary, the entity with a con-
tract under subsection (a), and any other entity the Secretary has contracted with to perform work.

“(4) A description of the activities for which the funds described in paragraph (2) were used, including task orders and activities assigned to the entity with a contract under subsection (a), activities performed by the Secretary, and task orders and activities assigned to any other entity the Secretary has contracted with to perform work related to carrying out section 1890A.

“(5) The amount of funding described in paragraph (2) that has been obligated or expended for each of the activities described in paragraph (4).

“(6) Estimates for, and descriptions of, obligations and expenditures that the Secretary anticipates will be needed in the succeeding two year period to carry out each of the quality measurement activities required under this section and section 1890A, including any obligations that will require funds to be expended in a future year.”.

(c) Revisions to Annual Report From Consensus-Based Entity to Congress and the Secretary.—
(1) IN GENERAL.—Section 1890(b)(5)(A) of the Social Security Act (42 U.S.C. 1395aaa(b)(5)(A)) is amended—

(A) by redesignating clauses (i) through (vi) as subclauses (I) through (VI), respectively, and moving the margins accordingly;

(B) in the matter preceding subclause (I), as redesignated by subparagraph (A), by striking “containing a description of—” and inserting “containing the following:

“(i) A description of—”; and

(C) by adding at the end the following new clauses:

“(ii) An itemization of financial information for the fiscal year ending September 30 of the preceding year, including—

“(I) annual revenues of the entity (including any government funding, private sector contributions, grants, membership revenues, and investment revenue);

“(II) annual expenses of the entity (including grants paid, benefits paid, salaries or other compensation,
fundraising expenses, and overhead costs); and

“(III) a breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity.

“(iii) Any updates or modifications of internal policies and procedures of the entity as they relate to the duties of the entity under this section, including—

“(I) specifically identifying any modifications to the disclosure of interests and conflicts of interests for committees, work groups, task forces, and advisory panels of the entity; and

“(II) information on external stakeholder participation in the duties of the entity under this section (including complete rosters for all committees, work groups, task forces, and advisory panels funded through government contracts, descriptions of relevant interests and any conflicts of interest for members of all committees,
work groups, task forces, and advisory panels, and the total percentage by health care sector of all convened committees, work groups, task forces, and advisory panels.”.

(2) Effective Date.—The amendments made by this subsection shall apply to reports submitted for years beginning with 2019.

(d) GAO Study and Report.—

(1) Study.—The Comptroller General of the United States shall conduct a study on health care quality measurement efforts funded under sections 1890 and 1890A of the Social Security Act (42 U.S.C. 1395aaa; 1395aaa–1). Such study shall include an examination of the following:

(A) The extent to which the Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) has set and prioritized objectives to be achieved for each of the quality measurement activities required under such sections 1890 and 1890A.

(B) The efforts that the Secretary has undertaken to meet quality measurement objectives associated with such sections 1890 and 1890A, including division of responsibilities for
those efforts within the Department of Health and Human Services and through contracts with a consensus-based entity under subsection (a) of such section 1890 (in this subsection referred to as the “consensus-based entity”) and other entities, and the extent of any overlap among the work performed by the Secretary, the consensus-based entity, the Measure Applications Partnership (MAP) convened by such entity to provide input to the Secretary on the selection of quality and efficiency measures, and any other entities the Secretary has contracted with to perform work related to carrying out such sections 1890 and 1890A.

(C) The total amount of funding provided to the Secretary for purposes of carrying out such sections 1890 and 1890A, the amount of such funding that has been obligated or expended by the Secretary, and the amount of such funding that remains unobligated.

(D) How the funds described in subparagraph (C) have been allocated, including how much of the funding has been allocated for work performed by the Secretary, the consensus-based entity, and any other entity the
Secretary has contracted with to perform work related to carrying out such sections 1890 and 1890A, respectively, and descriptions of such work.

(E) The extent to which the Secretary has developed a comprehensive and long-term plan to ensure that it can achieve quality measurement objectives related to carrying out such sections 1890 and 1890A in a timely manner and with efficient use of available resources, including the roles of the consensus-based entity, the Measure Applications Partnership (MAP), and any other entity the Secretary has contracted with to perform work related to such sections 1890 and 1890A in helping the Secretary achieve those objectives.

(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.
SEC. 50207. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS; STATE HEALTH INSURANCE ASSISTANCE PROGRAM REPORTING REQUIREMENTS.

(a) Funding Extensions.—


(A) in clause (vi), by striking “and” at the end;

(B) in clause (vii), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following new clauses:
“(viii) for fiscal year 2018, of $13,000,000; and
“(ix) for fiscal year 2019, of $13,000,000.”.

(2) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119, as so amended, is amended—

(A) in clause (vi), by striking “and” at the end;

(B) in clause (vii), by striking the period at the end and inserting “; and”; and

(C) by inserting after clause (vii) the following new clauses:

“(viii) for fiscal year 2018, of $7,500,000; and
“(ix) for fiscal year 2019, of $7,500,000.”.

(3) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119, as so amended, is amended—

(A) in clause (vi), by striking “and” at the end;

(B) in clause (vii), by striking the period at the end and inserting “; and”; and
(C) by inserting after clause (vii) the following new clauses:

“(viii) for fiscal year 2018, of $5,000,000; and

“(ix) for fiscal year 2019, of $5,000,000.”.

(4) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119, as so amended, is amended—

(A) in clause (vi), by striking “and” at the end;

(B) in clause (vii), by striking the period at the end and inserting “; and”; and

(C) by inserting after clause (vii) the following new clauses:

“(viii) for fiscal year 2018, of $12,000,000; and

“(ix) for fiscal year 2019, of $12,000,000.”.

(b) STATE HEALTH INSURANCE ASSISTANCE PROGRAM REPORTING REQUIREMENTS.—Beginning not later than April 1, 2019, and biennially thereafter, the Agency for Community Living shall electronically post on its website the following information, with respect to grants
to States for State health insurance assistance programs,
(such information to be presented by State and by entity
receiving funds from the State to carry out such a pro-
gram funded by such grant):

(1) The amount of Federal funding provided to
each such State for such program for the period in-
volved and the amount of Federal funding provided
by each such State for such program to each such
entity for the period involved.

(2) Information as the Secretary may specify,
with respect to such programs carried out through
such grants, consistent with the terms and condi-
tions for receipt of such grants.

SEC. 50208. EXTENSION OF HOME HEALTH RURAL ADD-ON.

(a) Extension.—

(1) In general.—Section 421 of the Medicare
Prescription Drug, Improvement, and Modernization
42 U.S.C. 1395fff note), as amended by section
5201(b) of the Deficit Reduction Act of 2005 (Pub-
lic Law 109–171; 120 Stat. 46), section 3131(c) of
the Patient Protection and Affordable Care Act
(Public Law 111–148; 124 Stat. 428), and section
210 of the Medicare Access and CHIP Reauthoriza-
tion Act of 2015 (Public Law 114–10; 129 Stat. 151) is amended—

(A) in subsection (a), by striking “January 1, 2018” and inserting “January 1, 2019” each place it appears;

(B) by redesignating subsections (b) and (c) as subsections (c) and (d), respectively;

(C) in each of subsections (c) and (d), as so redesignated, by striking “subsection (a)” and inserting “subsection (a) or (b)”;

(D) by inserting after subsection (a) the following new subsection:

“(b) SUBSEQUENT TEMPORARY INCREASE.—

“(1) IN GENERAL.—The Secretary shall increase the payment amount otherwise made under such section 1895 for home health services furnished in a county (or equivalent area) in a rural area (as defined in such section 1886(d)(2)(D)) that, as determined by the Secretary—

“(A) is in the highest quartile of all counties (or equivalent areas) based on the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled for benefits
under part B of such title (but not enrolled in a plan under part C of such title)—

“(i) in the case of episodes and visits ending during 2019, by 1.5 percent; and

“(ii) in the case of episodes and visits ending during 2020, by 0.5 percent;

“(B) has a population density of 6 individuals or fewer per square mile of land area and is not described in subparagraph (A)—

“(i) in the case of episodes and visits ending during 2019, by 4 percent;

“(ii) in the case of episodes and visits ending during 2020, by 3 percent;

“(iii) in the case of episodes and visits ending during 2021, by 2 percent; and

“(iv) in the case of episodes and visits ending during 2022, by 1 percent; and

“(C) is not described in either subparagraph (A) or (B)—

“(i) in the case of episodes and visits ending during 2019, by 3 percent;

“(ii) in the case of episodes and visits ending during 2020, by 2 percent; and

“(iii) in the case of episodes and visits ending during 2021, by 1 percent.
“(2) Rules for determinations.—

“(A) No switching.—For purposes of this subsection, the determination by the Secretary as to which subparagraph of paragraph (1) applies to a county (or equivalent area) shall be made a single time and shall apply for the duration of the period to which this subsection applies.

“(B) Utilization.—In determining which counties (or equivalent areas) are in the highest quartile under paragraph (1)(A), the following rules shall apply:

“(i) The Secretary shall use data from 2015.

“(ii) The Secretary shall exclude data from the territories (and the territories shall not be described in such paragraph).

“(iii) The Secretary may exclude data from counties (or equivalent areas) in rural areas with a low volume of home health episodes (and if data is so excluded with respect to a county (or equivalent area), such county (or equivalent area) shall not be described in such paragraph).
“(C) Population density.—In determining population density under paragraph (1)(B), the Secretary shall use data from the 2010 decennial Census.

“(3) Limitations on review.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of determinations under paragraph (1).”.

(2) Requirement to submit county data on claim form.—Section 1895(c) of the Social Security Act (42 U.S.C. 1395fff(c)) is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following new paragraph:

“(3) in the case of home health services furnished on or after January 1, 2019, the claim contains the code for the county (or equivalent area) in which the home health service was furnished.”.

(b) HHS OIG Analysis.—Not later than January 1, 2023, the Inspector General of the Department of Health and Human Services shall submit to Congress—
(1) an analysis of the home health claims and utilization of home health services by county (or equivalent area) under the Medicare program; and

(2) recommendations the Inspector General determines appropriate based on such analysis.

**TITLE III—CREATING HIGH-QUALITY RESULTS AND OUTCOMES NECESSARY TO IMPROVE CHRONIC (CHRONIC) CARE**

**Subtitle A—Receiving High Quality Care in the Home**

**SEC. 50301. EXTENDING THE INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.**

(a) In general.—Section 1866E of the Social Security Act (42 U.S.C. 1395cc–5) is amended—

(1) in subsection (e)—

(A) in paragraph (1)—

(i) by striking “An agreement” and inserting “Agreements”; and

(ii) by striking “5-year” and inserting “7-year”; and

(B) in paragraph (5)—

(i) by striking “10,000” and inserting “15,000”; and
(ii) by adding at the end the following new sentence: “An applicable beneficiary that participates in the demonstration program by reason of the increase from 10,000 to 15,000 in the preceding sentence pursuant to the amendment made by section 50301(a)(1)(B)(i) of the Advancing Chronic Care, Extenders, and Social Services Act shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the sixth and seventh years of such program.”;

(2) in subsection (g), in the first sentence, by inserting “, including, to the extent practicable, with respect to the use of electronic health information systems, as described in subsection (b)(1)(A)(vi)” after “under the demonstration program”; and

(3) in subsection (i)(1)(A), by striking “will not receive an incentive payment for the second of 2” and inserting “did not achieve savings for the third of 3”.
(b) **Effective Date.**—The amendment made by subsection (a)(3) shall take effect as if included in the enactment of Public Law 111–148.

**SEC. 50302. EXPANDING ACCESS TO HOME DIALYSIS THERAPY.**

(a) **In General.**—Section 1881(b)(3) of the Social Security Act (42 U.S.C. 1395rr(b)(3)) is amended—

1. by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;
2. in clause (ii), as redesignated by paragraph (1), by striking “on a comprehensive” and inserting “subject to subparagraph (B), on a comprehensive”; and
3. by striking “With respect to” and inserting “(A) With respect to”; and
4. by adding at the end the following new subparagraph:

“(B)(i) For purposes of subparagraph (A)(ii), subject to clause (ii), an individual determined to have end stage renal disease receiving home dialysis may choose to receive monthly end stage renal disease-related clinical assessments furnished on or after January 1, 2019, via telehealth.

“(ii) Clause (i) shall apply to an individual only if the individual receives a face-to-face clinical assessment, without the use of telehealth—
“(I) in the case of the initial 3 months of home dialysis of such individual, at least monthly; and
“(II) after such initial 3 months, at least once every 3 consecutive months.”.

(b) ORIGINATING SITE REQUIREMENTS.—

(1) IN GENERAL.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(A) in paragraph (4)(C)(ii), by adding at the end the following new subclauses:

“(IX) A renal dialysis facility, but only for purposes of section 1881(b)(3)(B).
“(X) The home of an individual, but only for purposes of section 1881(b)(3)(B).”;

and

(B) by adding at the end the following new paragraph:

“(5) TREATMENT OF HOME DIALYSIS MONTHLY ESRD-RELATED VISIT.—The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of section 1881(b)(3)(B), at an originating site described in
subclause (VI), (IX), or (X) of paragraph (4)(C)(ii).”.

(2) No facility fee if originating site for home dialysis therapy is the home.—Section 1834(m)(2)(B) of the Social Security (42 U.S.C. 1395m(m)(2)(B)) is amended—

(A) by redesignating clauses (i) and (ii) as subclauses (I) and (II), and indenting appropriately;

(B) in subclause (II), as redesignated by subparagraph (A), by striking “clause (i) or this clause” and inserting “subclause (I) or this subclause”;

(C) by striking “SITE.—With respect to” and inserting “SITE.—

“(i) In general.—Subject to clause (ii), with respect to”; and

(D) by adding at the end the following new clause:

“(ii) No facility fee if originating site for home dialysis therapy is the home.—No facility fee shall be paid under this subparagraph to an originating site described in paragraph (4)(C)(ii)(X).”.
(c) Clarification Regarding Telehealth Provided to Beneficiaries.—Section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) in subparagraph (H), by striking “or” at the end;

(2) in subparagraph (I), by striking the period at the end and inserting “; or”; and

(3) by adding at the end the following new sub-
paragraph:

“(J) the provision of telehealth tech-
nologies (as defined by the Secretary) on or after January 1, 2019, by a provider of services or a renal dialysis facility (as such terms are defined for purposes of title XVIII) to an indi-
vidual with end stage renal disease who is re-
ceiving home dialysis for which payment is being made under part B of such title, if—

“(i) the telehealth technologies are not offered as part of any advertisement or so-
licitation;

“(ii) the telehealth technologies are provided for the purpose of furnishing tele-
health services related to the individual’s end stage renal disease; and
“(iii) the provision of the telehealth technologies meets any other requirements set forth in regulations promulgated by the Secretary.”.

(d) CONFORMING AMENDMENT.—Section 1881(b)(1) of the Social Security Act (42 U.S.C. 1395rr(b)(1)) is amended by striking “paragraph (3)(A)” and inserting “paragraph (3)(A)(i)”.

Subtitle B—Advancing Team-Based Care

SEC. 50311. PROVIDING CONTINUED ACCESS TO MEDICARE ADVANTAGE SPECIAL NEEDS PLANS FOR VULNERABLE POPULATIONS.

(a) EXTENSION.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking “and for periods before January 1, 2019”.

(b) INCREASED INTEGRATION OF DUAL SNPs.—

(1) IN GENERAL.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended—

(A) in paragraph (3), by adding at the end the following new subparagraph:

“(F) The plan meets the requirements applicable under paragraph (8).”; and

(B) by adding at the end the following new paragraph:
“(8) INCREASED INTEGRATION OF DUAL SNPS.—

“(A) DESIGNATED CONTACT.—The Secretary, acting through the Federal Coordinated Health Care Office established under section 2602 of Public Law 111–148, shall serve as a dedicated point of contact for States to address misalignments that arise with the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this paragraph and, consistent with such role, shall establish—

“(i) a uniform process for disseminating to State Medicaid agencies information under this title impacting contracts between such agencies and such plans under this subsection; and

“(ii) basic resources for States interested in exploring such plans as a platform for integration, such as a model contract or other tools to achieve those goals.

“(B) UNIFIED GRIEVANCES AND APPEALS PROCESS.—

“(i) IN GENERAL.—Not later than April 1, 2020, the Secretary shall establish
procedures, to the extent feasible as determined by the Secretary, unifying grievances and appeals procedures under sections 1852(f), 1852(g), 1902(a)(3), 1902(a)(5), and 1932(b)(4) for items and services provided by specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this title and title XIX. With respect to items and services described in the preceding sentence, procedures established under this clause shall apply in place of otherwise applicable grievances and appeals procedures. The Secretary shall solicit comment in developing such procedures from States, plans, beneficiaries and their representatives, and other relevant stakeholders.

“(ii) PROCEDURES.—The procedures established under clause (i) shall be included in the plan contract under paragraph (3)(D) and shall—

“(I) adopt the provisions for the enrollee that are most protective for the enrollee and, to the extent feasible as determined by the Secretary, are
compatible with unified timeframes
and consolidated access to external re-
view under an integrated process;

“(II) take into account differ-
ences in State plans under title
XIX to the extent necessary;

“(III) be easily navigable by an
enrollee; and

“(IV) include the elements de-
scribed in clause (iii), as applicable.

“(iii) ELEMENTS DESCRIBED.—Both
unified appeals and unified grievance pro-
cedures shall include, as applicable, the fol-
lowing elements described in this clause:

“(I) Single written notification of
all applicable grievances and appeal
rights under this title and title XIX.
For purposes of this subparagraph,
the Secretary may waive the require-
ments under section 1852(g)(1)(B)
when the specialized MA plan covers
items or services under this part or
under title XIX.

“(II) Single pathways for resolu-
tion of any grievance or appeal related
to a particular item or service provided by specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this title and title XIX.

“(III) Notices written in plain language and available in a language and format that is accessible to the enrollee, including in non-English languages that are prevalent in the service area of the specialized MA plan.

“(IV) Unified timeframes for grievances and appeals processes, such as an individual’s filing of a grievance or appeal, a plan’s acknowledgment and resolution of a grievance or appeal, and notification of decisions with respect to a grievance or appeal.

“(V) Requirements for how the plan must process, track, and resolve grievances and appeals, to ensure beneficiaries are notified on a timely basis of decisions that are made throughout the grievance or appeals process and are able to easily deter-
mine the status of a grievance or appeal.

“(iv) Continuation of Benefits Pending Appeal.—The unified procedures under clause (i) shall, with respect to all benefits under parts A and B and title XIX subject to appeal under such procedures, incorporate provisions under current law and implementing regulations that provide continuation of benefits pending appeal under this title and title XIX.

“(C) Requirement for Unified Grievances and Appeals.—For 2021 and subsequent years, the contract of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) with a State Medicaid agency under paragraph (3)(D) shall require the use of unified grievances and appeals procedures as described in subparagraph (B).

“(D) Requirements for Integration.—

“(i) In General.—For 2021 and subsequent years, a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) shall meet one or
more of the following requirements, to the extent permitted under State law, for integration of benefits under this title and title XIX:

“(I) The specialized MA plan must meet the requirements of contracting with the State Medicaid agency described in paragraph (3)(D) in addition to coordinating long-term services and supports or behavioral health services, or both, by meeting an additional minimum set of requirements determined by the Secretary through the Federal Coordinated Health Care Office established under section 2602 of the Patient Protection and Affordable Care Act based on input from stakeholders, such as notifying the State in a timely manner of hospitalizations, emergency room visits, and hospital or nursing home discharges of enrollees, assigning one primary care provider for each enrollee, or sharing data that would benefit the coordination of items and
services under this title and the State plan under title XIX. Such minimum set of requirements must be included in the contract of the specialized MA plan with the State Medicaid agency under such paragraph.

“(II) The specialized MA plan must meet the requirements of a fully integrated plan described in section 1853(a)(1)(B)(iv)(II) (other than the requirement that the plan have similar average levels of frailty, as determined by the Secretary, as the PACE program), or enter into a capitated contract with the State Medicaid agency to provide long-term services and supports or behavioral health services, or both.

“(III) In the case of a specialized MA plan that is offered by a parent organization that is also the parent organization of a Medicaid managed care organization providing long term services and supports or behavioral services under a contract under sec-
tion 1903(m), the parent organization must assume clinical and financial responsibility for benefits provided under this title and title XIX with respect to any individual who is enrolled in both the specialized MA plan and the Medicaid managed care organization.

“(ii) SUSPENSION OF ENROLLMENT FOR FAILURE TO MEET REQUIREMENTS DURING INITIAL PERIOD.—During the period of plan years 2021 through 2025, if the Secretary determines that a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) has failed to comply with clause (i), the Secretary may provide for the application against the Medicare Advantage organization offering the plan of the remedy described in section 1857(g)(2)(B) in the same manner as the Secretary may apply such remedy, and in accordance with the same procedures as would apply, in the case of an MA organization determined by the Secretary to have engaged in conduct
described in section 1857(g)(1). If the Secretary applies such remedy to a Medicare Advantage organization under the preceding sentence, the organization shall submit to the Secretary (at a time, and in a form and manner, specified by the Secretary) information describing how the plan will come into compliance with clause (i).

“(E) STUDY AND REPORT TO CONGRESS.—

“(i) In general.—Not later than March 15, 2022, and, subject to clause (iii), biennially thereafter through 2032, the Medicare Payment Advisory Commission established under section 1805, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900, shall conduct (and submit to the Secretary and the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on) a study to determine how specialized MA plans for special needs individuals described in subsection
(b)(6)(B)(ii) perform among each other based on data from Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, reported on the plan level, as required under section 1852(c)(3) (or such other measures or data sources that are available and appropriate, such as encounter data and Consumer Assessment of Healthcare Providers and Systems data, as specified by such Commissions as enabling an accurate evaluation under this subparagraph). Such study shall include, as feasible, the following comparison groups of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii):

“(I) A comparison group of such plans that are described in subparagraph (D)(i)(I).

“(II) A comparison group of such plans that are described in subparagraph (D)(i)(II).

“(III) A comparison group of such plans operating within the Financial Alignment Initiative dem-
onstration for the period for which such plan is so operating and the demonstration is in effect, and, in the case that an integration option that is not with respect to specialized MA plans for special needs individuals is established after the conclusion of the demonstration involved.

“(IV) A comparison group of such plans that are described in subparagraph (D)(i)(III).

“(V) A comparison group of MA plans, as feasible, not described in a previous subclause of this clause, with respect to the performance of such plans for enrollees who are special needs individuals described in subsection (b)(6)(B)(ii).

“(ii) ADDITIONAL REPORTS.—Beginning with 2033 and every five years thereafter, the Medicare Payment Advisory Commission, in consultation with the Medicaid and CHIP Payment and Access Commission, shall conduct a study described in clause (i).”
(2) Conforming Amendment to Responsibilities of Federal Coordinated Health Care Office.—Section 2602(d) of Public Law 111–148 (42 U.S.C. 1315b(d)) is amended by adding at the end the following new paragraphs:

“(6) To act as a designated contact for States under subsection (f)(8)(A) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28) with respect to the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of such section.

“(7) To be responsible, subject to the final approval of the Secretary, for developing regulations and guidance related to the implementation of a unified grievance and appeals process as described in subparagraphs (B) and (C) of section 1859(f)(8) of the Social Security Act (42 U.S.C. 1395w–28(f)(8)).

“(8) To be responsible, subject to the final approval of the Secretary, for developing regulations and guidance related to the integration or alignment of policy and oversight under the Medicare program under title XVIII of such Act and the Medicaid program under title XIX of such Act regarding specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of such section 1859.”.
(c) Improvements to Severe or Disabling Chronic Condition SNPs.—

(1) Care management requirements.—Section 1859(f)(5) of the Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amended—

(A) by striking “ALL SNPS.—The requirements” and inserting “ALL SNPS.—

“(A) In general.—Subject to subparagraph (B), the requirements”;

(B) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting appropriately; and

(C) in clause (ii), as redesignated by subparagraph (B), by redesignating clauses (i) through (iii) as subclauses (I) through (III), respectively, and indenting appropriately; and

(D) by adding at the end the following new subparagraph:

“(B) Improvements to care management requirements for severe or disabling chronic condition SNPs.—For 2020 and subsequent years, in the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the require-
ments described in this paragraph include the following:

“(i) The interdisciplinary team under subparagraph (A)(ii)(III) includes a team of providers with demonstrated expertise, including training in an applicable specialty, in treating individuals similar to the targeted population of the plan.

“(ii) Requirements developed by the Secretary to provide face-to-face encounters with individuals enrolled in the plan not less frequently than on an annual basis.

“(iii) As part of the model of care under clause (i) of subparagraph (A), the results of the initial assessment and annual reassessment under clause (ii)(I) of such subparagraph of each individual enrolled in the plan are addressed in the individual’s individualized care plan under clause (ii)(II) of such subparagraph.

“(iv) As part of the annual evaluation and approval of such model of care, the Secretary shall take into account whether
the plan fulfilled the previous year’s goals (as required under the model of care).

“(v) The Secretary shall establish a minimum benchmark for each element of the model of care of a plan. The Secretary shall only approve a plan’s model of care under this paragraph if each element of the model of care meets the minimum benchmark applicable under the preceding sentence.”

(2) Revisions to the definition of a severe or disabling chronic conditions specialized needs individual.—

(A) In general.—Section 1859(b)(6)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(iii)) is amended—

(i) by striking “who have” and inserting “who—

“(I) before January 1, 2022, have”;

(ii) in subclause (I), as added by clause (i), by striking the period at the end and inserting “; and”; and
(iii) by adding at the end the following new subclause:

“(II) on or after January 1, 2022, have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits overall health or function, have a high risk of hospitalization or other adverse health outcomes, and require intensive care coordination and that is listed under subsection (f)(9)(A).”.

(B) PANEL OF CLINICAL ADVISORS.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsection (b), is amended by adding at the end the following new paragraph:

“(9) LIST OF CONDITIONS FOR CLARIFICATION OF THE DEFINITION OF A SEVERE OR DISABLING CHRONIC CONDITIONS SPECIALIZED NEEDS INDIVIDUAL.—

“(A) IN GENERAL.—Not later than December 31, 2020, and every 5 years thereafter, subject to subparagraphs (B) and (C), the Secretary shall convene a panel of clinical advisors
to establish and update a list of conditions that meet each of the following criteria:

“(i) Conditions that meet the definition of a severe or disabling chronic condition under subsection (b)(6)(B)(iii) on or after January 1, 2022.

“(ii) Conditions that require prescription drugs, providers, and models of care that are unique to the specific population of enrollees in a specialized MA plan for special needs individuals described in such subsection on or after such date and—

“(I) as a result of access to, and enrollment in, such a specialized MA plan for special needs individuals, individuals with such condition would have a reasonable expectation of slowing or halting the progression of the disease, improving health outcomes and decreasing overall costs for individuals diagnosed with such condition compared to available options of care other than through such a specialized MA plan for special needs individuals; or
“(II) have a low prevalence in the general population of beneficiaries under this title or a disproportionally high per-beneficiary cost under this title.

“(B) Inclusion of Certain Conditions.—The conditions listed under subparagraph (A) shall include HIV/AIDS, end stage renal disease, and chronic and disabling mental illness.

“(C) Requirement.—In establishing and updating the list under subparagraph (A), the panel shall take into account the availability of varied benefits, cost-sharing, and supplemental benefits under the model described in paragraph (2) of section 1859(h), including the expansion under paragraph (1) of such section.”.

(d) Quality Measurement at the Plan Level for SNPs and Determination of Feasability of Quality Measurement at the Plan Level for All MA Plans.—Section 1853(o) of the Social Security Act (42 U.S.C. 1395w–23(o)) is amended by adding at the end the following new paragraphs:

“(6) Quality Measurement at the Plan Level for SNPs.—
“(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may require reporting of data under section 1852(c) for, and apply under this subsection, quality measures at the plan level for specialized MA plans for special needs individuals instead of at the contract level.

“(B) CONSIDERATIONS.—Prior to applying quality measurement at the plan level under this paragraph, the Secretary shall—

“(i) take into consideration the minimum number of enrollees in a specialized MA plan for special needs individuals in order to determine if a statistically significant or valid measurement of quality at the plan level is possible under this paragraph;

“(ii) take into consideration the impact of such application on plans that serve a disproportionate number of individuals dually eligible for benefits under this title and under title XIX;

“(iii) if quality measures are reported at the plan level, ensure that MA plans are
not required to provide duplicative information; and

“(iv) ensure that such reporting does not interfere with the collection of encounter data submitted by MA organizations or the administration of any changes to the program under this part as a result of the collection of such data.

“(C) APPLICATION.—If the Secretary applies quality measurement at the plan level under this paragraph—

“(i) such quality measurement may include Medicare Health Outcomes Survey (HOS), Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and quality measures under part D; and

“(ii) the Secretary shall consider applying administrative actions, such as remedies described in section 1857(g)(2), at the plan level.

“(7) DETERMINATION OF FEASIBILITY OF QUALITY MEASUREMENT AT THE PLAN LEVEL FOR ALL MA PLANS.—
“(A) Determination of Feasibility.—

The Secretary shall determine the feasibility of requiring reporting of data under section 1852(e) for, and applying under this subsection, quality measures at the plan level for all MA plans under this part.

“(B) Consideration of Change.—After making a determination under subparagraph (A), the Secretary shall consider requiring such reporting and applying such quality measures at the plan level as described in such subparagraph”.

(e) GAO Study and Report on State-Level Integration Between Dual SNPs and Medicaid.—

(1) Study.—The Comptroller General of the United States (in this subsection referred to as the “Comptroller General’’) shall conduct a study on State-level integration between specialized MA plans for special needs individuals described in subsection (b)(6) (B)(ii) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28) and the Medicaid pro-

gram under title XIX of such Act (42 U.S.C. 1396 et seq.). Such study shall include an analysis of the following:
(A) The characteristics of States in which the State agency responsible for administering the State plan under such title XIX has a contract with such a specialized MA plan and that delivers long-term services and supports under the State plan under such title XIX through a managed care program, including the requirements under such State plan with respect to long-term services and supports.

(B) The types of such specialized MA plans, which may include the following:

(i) A plan described in section 1853(a)(1)(B)(iv)(II) of such Act (42 U.S.C. 1395w–23(a)(1)(B)(iv)(II)).

(ii) A plan that meets the requirements described in subsection (f)(3)(D) of such section 1859.

(iii) A plan described in clause (ii) that also meets additional requirements established by the State.

(C) The characteristics of individuals enrolled in such specialized MA plans.

(D) As practicable, the following with respect to State programs for the delivery of long-
term services and supports under such title XIX through a managed care program:

(i) Which populations of individuals are eligible to receive such services and supports.

(ii) Whether all such services and supports are provided on a capitated basis or if any of such services and supports are carved out and provided through fee-for-service.

(E) As practicable, how the availability and variation of integration arrangements of such specialized MA plans offered in States affects spending, service delivery options, access to community-based care, and utilization of care.

(F) The efforts of State Medicaid programs to transition dually-eligible beneficiaries receiving long-term services and supports (LTSS) from institutional settings to home and community-based settings and related financial impacts of such transitions.

(G) Barriers and opportunities for making further progress on dual integration, as well as recommendations for legislation or administra-
tive action to expedite or refine pathways to-
ward fully integrated care.

(2) REPORT.—Not later than 2 years after the
date of the enactment of this Act, the Comptroller
General shall submit to Congress a report containing
the results of the study conducted under paragraph
(1), together with recommendations for such legisla-
tion and administrative action as the Comptroller
General determines appropriate.

Subtitle C—Expanding Innovation
and Technology

SEC. 50321. ADAPTING BENEFITS TO MEET THE NEEDS OF
CHRONICALLY ILL MEDICARE ADVANTAGE
ENROLLEES.

Section 1859 of the Social Security Act (42 U.S.C.
1395w–28) is amended by adding at the end the following
new subsection:

“(h) NATIONAL TESTING OF MEDICARE ADVANTAGE
VALUE-BASED INSURANCE DESIGN MODEL.—

“(1) IN GENERAL.—In implementing the Medi-
care Advantage Value-Based Insurance Design
model that is being tested under section 1115A(b),
the Secretary shall revise the testing of the model
under such section to cover, effective not later than
January 1, 2020, all States.
“(2) TERMINATION AND MODIFICATION PROVISION NOT APPLICABLE UNTIL JANUARY 1, 2022.—

The provisions of section 1115A(b)(3)(B) shall apply to the Medicare Advantage Value-Based Insurance Design model, including such model as revised under paragraph (1), beginning January 1, 2022, but shall not apply to such model, as so revised, prior to such date.

“(3) FUNDING.—The Secretary shall allocate funds made available under section 1115A(f)(1) to design, implement, and evaluate the Medicare Advantage Value-Based Insurance Design model, as revised under paragraph (1).”.

SEC. 50322. EXPANDING SUPPLEMENTAL BENEFITS TO MEET THE NEEDS OF CHRONICALLY ILL MEDICARE ADVANTAGE ENROLLEES.

(a) IN GENERAL.—Section 1852(a)(3) of the Social Security Act (42 U.S.C. 1395w–22(a)(3)) is amended—

(1) in subparagraph (A), by striking “Each” and inserting “Subject to subparagraph (D), each”; and

(2) by adding at the end the following new subparagraph:
“(D) EXPANDING SUPPLEMENTAL BENEFITS TO MEET THE NEEDS OF CHRONICALLY ILL ENROLLEES.—

“(i) IN GENERAL.—For plan year 2020 and subsequent plan years, in addition to any supplemental health care benefits otherwise provided under this paragraph, an MA plan, including a specialized MA plan for special needs individuals (as defined in section 1859(b)(6)), may provide supplemental benefits described in clause (ii) to a chronically ill enrollee (as defined in clause (iii)).

“(ii) SUPPLEMENTAL BENEFITS DESCRIBED.—

“(I) IN GENERAL.—Supplemental benefits described in this clause are supplemental benefits that, with respect to a chronically ill enrollee, have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.
“(II) Authority to waive uniformity requirements.—The Secretary may, only with respect to supplemental benefits provided to a chronically ill enrollee under this subparagraph, waive the uniformity requirements under this part, as determined appropriate by the Secretary.

“(iii) Chronically ill enrollee defined.—In this subparagraph, the term ‘chronically ill enrollee’ means an enrollee in an MA plan that the Secretary determines—

“(I) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;

“(II) has a high risk of hospitalization or other adverse health outcomes; and

“(III) requires intensive care coordination.”.

(b) GAO study and report.—
(1) Study.—The Comptroller General of the United States (in this subsection referred to as the “Comptroller General”) shall conduct a study on supplemental benefits provided to enrollees in Medicare Advantage plans under part C of title XVIII of the Social Security Act, including specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of such Act (42 U.S.C. 1395w–28(b)(6))). To the extent data are available, such study shall include an analysis of the following:

(A) The type of supplemental benefits provided to such enrollees, the total number of enrollees receiving each supplemental benefit, and whether the supplemental benefit is covered by the standard benchmark cost of the benefit or with an additional premium.

(B) The frequency in which supplemental benefits are utilized by such enrollees.

(C) The impact supplemental benefits have on—

(i) indicators of the quality of care received by such enrollees, including overall health and function of the enrollees;

(ii) the utilization of items and services for which benefits are available under
the original Medicare fee-for-service program option under parts A and B of such title XVIII by such enrollees; and

(iii) the amount of the bids submitted by Medicare Advantage Organizations for Medicare Advantage plans under such part C.

(2) CONSULTATION.—In conducting the study under paragraph (1), the Comptroller General shall, as necessary, consult with the Centers for Medicare & Medicaid Services and Medicare Advantage organizations offering Medicare Advantage plans.

(3) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 50323. INCREASING CONVENIENCE FOR MEDICARE ADVANTAGE ENROLLEES THROUGH TELEHEALTH.

(a) IN GENERAL.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended—
(1) in subsection (a)(1)(B)(i), by inserting “,
subject to subsection (m),” after “means”; and

(2) by adding at the end the following new sub-
section:

“(m) Provision of Additional Telehealth
Benefits.—

“(1) MA plan option.—For plan year 2020
and subsequent plan years, subject to the require-
ments of paragraph (3), an MA plan may provide
additional telehealth benefits (as defined in para-
graph (2)) to individuals enrolled under this part.

“(2) Additional telehealth benefits de-

fined.—

“(A) In general.—For purposes of this
subsection and section 1854:

“(i) Definition.—The term ‘addi-
tional telehealth benefits’ means services—

“(I) for which benefits are avail-
able under part B, including services
for which payment is not made under
section 1834(m) due to the conditions
for payment under such section; and

“(II) that are identified for such
year as clinically appropriate to fur-
nish using electronic information and
telecommunications technology when a physician (as defined in section 1861(r)) or practitioner (described in section 1842(b)(18)(C)) providing the service is not at the same location as the plan enrollee.

“(ii) EXCLUSION OF CAPITAL AND INFRASTRUCTURE COSTS AND INVESTMENTS.—The term ‘additional telehealth benefits’ does not include capital and infrastructure costs and investments relating to such benefits.

“(B) PUBLIC COMMENT.—Not later than November 30, 2018, the Secretary shall solicit comments on—

“(i) what types of items and services (including those provided through supplemental health care benefits, such as remote patient monitoring, secure messaging, store and forward technologies, and other non-face-to-face communication) should be considered to be additional telehealth benefits; and
“(ii) the requirements for the provision or furnishing of such benefits (such as training and coordination requirements).

“(3) REQUIREMENTS FOR ADDITIONAL TELEHEALTH BENEFITS.—The Secretary shall specify requirements for the provision or furnishing of additional telehealth benefits, including with respect to the following:

“(A) Physician or practitioner qualifications (other than licensure) and other requirements such as specific training.

“(B) Factors necessary for the coordination of such benefits with other items and services including those furnished in-person.

“(C) Such other areas as determined by the Secretary.

“(4) ENROLLEE CHOICE.—If an MA plan provides a service as an additional telehealth benefit (as defined in paragraph (2))—

“(A) the MA plan shall also provide access to such benefit through an in-person visit (and not only as an additional telehealth benefit); and

“(B) an individual enrollee shall have discretion as to whether to receive such service
through the in-person visit or as an additional telehealth benefit.

“(5) TREATMENT UNDER MA.—For purposes of this subsection and section 1854, if a plan provides additional telehealth benefits, such additional telehealth benefits shall be treated as if they were benefits under the original Medicare fee-for-service program option.

“(6) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the requirement under subsection (a)(1) that MA plans provide enrollees with items and services (other than hospice care) for which benefits are available under parts A and B, including benefits available under section 1834(m).”.

(b) CLARIFICATION REGARDING INCLUSION IN BID AMOUNT.—Section 1854(a)(6)(A)(ii)(I) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(A)(ii)(I)) is amended by inserting “, including, for plan year 2020 and subsequent plan years, the provision of additional telehealth benefits as described in section 1852(m)” before the semicolon at the end.
SEC. 50324. PROVIDING ACCOUNTABLE CARE ORGANIZATIONS THE ABILITY TO EXPAND THE USE OF TELEHEALTH.

(a) IN GENERAL.—Section 1899 of the Social Security Act (42 U.S.C. 1395jjjj) is amended by adding at the end the following new subsection:

“(l) PROVIDING ACOs THE ABILITY TO EXPAND THE USE OF TELEHEALTH SERVICES.—

“(1) IN GENERAL.—In the case of telehealth services for which payment would otherwise be made under this title furnished on or after January 1, 2020, for purposes of this subsection only, the following shall apply with respect to such services furnished by a physician or practitioner participating in an applicable ACO (as defined in paragraph (2)) to a Medicare fee-for-service beneficiary assigned to the applicable ACO:

“(A) INCLUSION OF HOME AS ORIGINATING SITE.—Subject to paragraph (3), the home of a beneficiary shall be treated as an originating site described in section 1834(m)(4)(C)(ii).

“(B) NO APPLICATION OF GEOGRAPHIC LIMITATION.—The geographic limitation under section 1834(m)(4)(C)(i) shall not apply with respect to an originating site described in section 1834(m)(4)(C)(ii) (including the home of a beneficiary).
beneficiary under subparagraph (A)), subject to
State licensing requirements.

“(2) DEFINITIONS.—In this subsection:

“(A) APPLICABLE ACO.—The term ‘applica-
cable ACO’ means an ACO participating in a
model tested or expanded under section 1115A
or under this section—

“(i) that operates under a two-sided
model—

“(I) described in section
425.600(a) of title 42, Code of Fed-
eral Regulations; or

“(II) tested or expanded under
section 1115A; and

“(ii) for which Medicare fee-for-serv-
ience beneficiaries are assigned to the ACO
using a prospective assignment method, as
determined appropriate by the Secretary.

“(B) HOME.—The term ‘home’ means,
with respect to a Medicare fee-for-service bene-
iciary, the place of residence used as the home
of the beneficiary.

“(3) TELEHEALTH SERVICES RECEIVED IN THE
HOME.—In the case of telehealth services described
in paragraph (1) where the home of a Medicare fee-
for-service beneficiary is the originating site, the fol-
lowing shall apply:

“(A) NO FACILITY FEE.—There shall be
no facility fee paid to the originating site under
section 1834(m)(2)(B).

“(B) EXCLUSION OF CERTAIN SERVICES.—
No payment may be made for such services that
are inappropriate to furnish in the home setting
such as services that are typically furnished in
inpatient settings such as a hospital.”.

(b) STUDY AND REPORT.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary of
Health and Human Services (in this subsection
referred to as the “Secretary”) shall conduct a
study on the implementation of section 1899(l)
of the Social Security Act, as added by sub-
section (a). Such study shall include an analysis
of the utilization of, and expenditures for, tele-
health services under such section.

(B) COLLECTION OF DATA.—The Sec-
retary may collect such data as the Secretary
determines necessary to carry out the study
under this paragraph.
(2) REPORT.—Not later than January 1, 2026, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 50325. EXPANDING THE USE OF TELEHEALTH FOR INDIVIDUALS WITH STROKE.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), as amended by section 50302(b)(1), is amended—

(1) in paragraph (4)(C)(i), in the matter preceding subclause (I), by striking “‘The term’” and inserting “‘Except as provided in paragraph (6), the term’”; and

(2) by adding at the end the following new paragraph:

“(6) TREATMENT OF STROKE TELEHEALTH SERVICES.—

“(A) NON-APPLICATION OF ORIGINATING SITE REQUIREMENTS.—The requirements described in paragraph (4)(C) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of
an acute stroke, as determined by the Secretary.

“(B) Inclusion of certain sites.—

With respect to telehealth services described in subparagraph (A), the term ‘originating site’ shall include any hospital (as defined in section 1861(e)) or critical access hospital (as defined in section 1861(mm)(1)), any mobile stroke unit (as defined by the Secretary), or any other site determined appropriate by the Secretary, at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system.

“(C) No originating site facility fee for new sites.—No facility fee shall be paid under paragraph (2)(B) to an originating site with respect to a telehealth service described in subparagraph (A) if the originating site does not otherwise meet the requirements for an originating site under paragraph (4)(C).”.
Subtitle D—Identifying the Chronically Ill Population

SEC. 50331. PROVIDING FLEXIBILITY FOR BENEFICIARIES TO BE PART OF AN ACCOUNTABLE CARE ORGANIZATION.

Section 1899(c) of the Social Security Act (42 U.S.C. 1395jjjj(c)) is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting appropriately;

(2) by striking “ACO S.—The Secretary” and inserting “ACOS.—

“(1) In general.—Subject to paragraph (2), the Secretary”; and

(3) by adding at the end the following new paragraph:

“(2) Providing flexibility.—

“(A) Choice of prospective assignment.—For each agreement period (effective for agreements entered into or renewed on or after January 1, 2020), in the case where an ACO established under the program is in a Track that provides for the retrospective assignment of Medicare fee-for-service beneficiaries to the ACO, the Secretary shall permit the ACO
to choose to have Medicare fee-for-service beneficiaries assigned prospectively, rather than retrospectively, to the ACO for an agreement period.

“(B) ASSIGNMENT BASED ON VOLUNTARY IDENTIFICATION BY MEDICARE FEE-FOR-SERVICE BENEFICIARIES.—

“(i) IN GENERAL.—For performance year 2018 and each subsequent performance year, if a system is available for electronic designation, the Secretary shall permit a Medicare fee-for-service beneficiary to voluntarily identify an ACO professional as the primary care provider of the beneficiary for purposes of assigning such beneficiary to an ACO, as determined by the Secretary.

“(ii) NOTIFICATION PROCESS.—The Secretary shall establish a process under which a Medicare fee-for-service beneficiary is—

“(I) notified of their ability to make an identification described in clause (i); and
“(II) informed of the process by which they may make and change such identification.

“(iii) SUPERSEDING CLAIMS-BASED ASSIGNMENT.—A voluntary identification by a Medicare fee-for-service beneficiary under this subparagraph shall supersede any claims-based assignment otherwise determined by the Secretary.”.

Subtitle E—Empowering Individuals and Caregivers in Care Delivery

SEC. 50341. ELIMINATING BARRIERS TO CARE COORDINATION UNDER ACCOUNTABLE CARE ORGANIZATIONS.

(a) In General.—Section 1899 of the Social Security Act (42 U.S.C. 1395jjj), as amended by section 50324(a), is amended—

(1) in subsection (b)(2), by adding at the end the following new subparagraph:

“(I) An ACO that seeks to operate an ACO Beneficiary Incentive Program pursuant to subsection (m) shall apply to the Secretary at such time, in such manner, and with such information as the Secretary may require.”;
(2) by adding at the end the following new subsection:

“(m) Authority To Provide Incentive Payments to Beneficiaries With Respect to Qualifying Primary Care Services.—

“(1) PROGRAM.—

“(A) IN GENERAL.—In order to encourage Medicare fee-for-service beneficiaries to obtain medically necessary primary care services, an ACO participating under this section under a payment model described in clause (i) or (ii) of paragraph (2)(B) may apply to establish an ACO Beneficiary Incentive Program to provide incentive payments to such beneficiaries who are furnished qualifying services in accordance with this subsection. The Secretary shall permit such an ACO to establish such a program at the Secretary’s discretion and subject to such requirements, including program integrity requirements, as the Secretary determines necessary.

“(B) IMPLEMENTATION.—The Secretary shall implement this subsection on a date determined appropriate by the Secretary. Such date
shall be no earlier than January 1, 2019, and no later than January 1, 2020.

“(2) Conduct of Program.—

“(A) Duration.—Subject to subparagraph (H), an ACO Beneficiary Incentive Program established under this subsection shall be conducted for such period (of not less than 1 year) as the Secretary may approve.

“(B) Scope.—An ACO Beneficiary Incentive Program established under this subsection shall provide incentive payments to all of the following Medicare fee-for-service beneficiaries who are furnished qualifying services by the ACO:

“(i) With respect to the Track 2 and Track 3 payment models described in section 425.600(a) of title 42, Code of Federal Regulations (or in any successor regulation), Medicare fee-for-service beneficiaries who are preliminarily prospectively or prospectively assigned (or otherwise assigned, as determined by the Secretary) to the ACO.

“(ii) With respect to any future payment models involving two-sided risk,
Medicare fee-for-service beneficiaries who are assigned to the ACO, as determined by the Secretary.

“(C) QUALIFYING SERVICE.—For purposes of this subsection, a qualifying service is a primary care service, as defined in section 425.20 of title 42, Code of Federal Regulations (or in any successor regulation), with respect to which coinsurance applies under part B, furnished through an ACO by—

“(i) an ACO professional described in subsection (h)(1)(A) who has a primary care specialty designation included in the definition of primary care physician under section 425.20 of title 42, Code of Federal Regulations (or any successor regulation);

“(ii) an ACO professional described in subsection (h)(1)(B); or

“(iii) a Federally qualified health center or rural health clinic (as such terms are defined in section 1861(aa)).

“(D) INCENTIVE PAYMENTS.—An incentive payment made by an ACO pursuant to an ACO Beneficiary Incentive Program established under this subsection shall be—
“(i) in an amount up to $20, with such maximum amount updated annually by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

“(ii) in the same amount for each Medicare fee-for-service beneficiary described in clause (i) or (ii) of subparagraph (B) without regard to enrollment of such a beneficiary in a medicare supplemental policy (described in section 1882(g)(1)), in a State Medicaid plan under title XIX or a waiver of such a plan, or in any other health insurance policy or health benefit plan;

“(iii) made for each qualifying service furnished to such a beneficiary described in clause (i) or (ii) of subparagraph (B) during a period specified by the Secretary;

and

“(iv) made no later than 30 days after a qualifying service is furnished to such a
beneficiary described in clause (i) or (ii) of subparagraph (B).

“(E) NO SEPARATE PAYMENTS FROM THE SECRETARY.—The Secretary shall not make any separate payment to an ACO for the costs, including incentive payments, of carrying out an ACO Beneficiary Incentive Program established under this subsection. Nothing in this subparagraph shall be construed as prohibiting an ACO from using shared savings received under this section to carry out an ACO Beneficiary Incentive Program.

“(F) NO APPLICATION TO SHARED SAVINGS CALCULATION.—Incentive payments made by an ACO under this subsection shall be disregarded for purposes of calculating benchmarks, estimated average per capita Medicare expenditures, and shared savings under this section.

“(G) REPORTING REQUIREMENTS.—An ACO conducting an ACO Beneficiary Incentive Program under this subsection shall, at such times and in such format as the Secretary may require, report to the Secretary such information and retain such documentation as the Sec-
retary may require, including the amount and
frequency of incentive payments made and the
number of Medicare fee-for-service beneficiaries
receiving such payments.

“(H) TERMINATION.—The Secretary may
terminate an ACO Beneficiary Incentive Pro-
gram established under this subsection at any
time for reasons determined appropriate by the
Secretary.

“(3) EXCLUSION OF INCENTIVE PAYMENTS.—
Any payment made under an ACO Beneficiary In-
centive Program established under this subsection
shall not be considered income or resources or other-
wise taken into account for purposes of—

“(A) determining eligibility for benefits or
assistance (or the amount or extent of benefits
or assistance) under any Federal program or
under any State or local program financed in
whole or in part with Federal funds; or

“(B) any Federal or State laws relating to
taxation.”;

(3) in subsection (e), by inserting “, including
an ACO Beneficiary Incentive Program under sub-
sections (b)(2)(I) and (m)” after “the program”;
(4) in subsection (g)(6), by inserting “or of an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)” after “under subsection (d)(4)”.

(b) Amendment to Section 1128B.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking “and” at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting “; and”; and

(3) by adding at the end the following new subparagraph:

“(K) an incentive payment made to a Medicare fee-for-service beneficiary by an ACO under an ACO Beneficiary Incentive Program established under subsection (m) of section 1899, if the payment is made in accordance with the requirements of such subsection and meets such other conditions as the Secretary may establish.”.

(c) Evaluation and Report.—

(1) Evaluation.—The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall conduct an evaluation of
the ACO Beneficiary Incentive Program established
under subsections (b)(2)(I) and (m) of section 1899
of the Social Security Act (42 U.S.C. 1395jjj), as
added by subsection (a). The evaluation shall include
an analysis of the impact of the implementation of
the Program on expenditures and beneficiary health
outcomes under title XVIII of the Social Security
Act (42 U.S.C. 1395 et seq.).

(2) REPORT.—Not later than October 1, 2023,
the Secretary shall submit to Congress a report con-
taining the results of the evaluation under para-
graph (1), together with recommendations for such
legislation and administrative action as the Sec-
retary determines appropriate.

SEC. 50342. GAO STUDY AND REPORT ON LONGITUDINAL
COMPREHENSIVE CARE PLANNING SERVICES
UNDER MEDICARE PART B.

(a) STUDY.—The Comptroller General shall conduct
a study on the establishment under part B of the Medicare
program under title XVIII of the Social Security Act of
a payment code for a visit for longitudinal comprehensive
care planning services. Such study shall include an anal-
ysis of the following to the extent such information is
available:
(1) The frequency with which services similar to longitudinal comprehensive care planning services are furnished to Medicare beneficiaries, which providers of services and suppliers are furnishing those services, whether Medicare reimbursement is being received for those services, and, if so, through which codes those services are being reimbursed.

(2) Whether, and the extent to which, longitudinal comprehensive care planning services would overlap, and could therefore result in duplicative payment, with services covered under the hospice benefit as well as the chronic care management code, evaluation and management codes, or other codes that already exist under part B of the Medicare program.

(3) Any barriers to hospitals, skilled nursing facilities, hospice programs, home health agencies, and other applicable providers working with a Medicare beneficiary to engage in the care planning process and complete the necessary documentation to support the treatment and care plan of the beneficiary and provide such documentation to other providers and the beneficiary or the beneficiary’s representative.
(4) Any barriers to providers, other than the provider furnishing longitudinal comprehensive care planning services, accessing the care plan and associated documentation for use related to the care of the Medicare beneficiary.

(5) Potential options for ensuring that applicable providers are notified of a patient’s existing longitudinal care plan and that applicable providers consider that plan in making their treatment decisions, and what the challenges might be in implementing such options.

(6) Stakeholder’s views on the need for the development of quality metrics with respect to longitudinal comprehensive care planning services, such as measures related to—

(A) the process of eliciting input from the Medicare beneficiary or from a legally authorized representative and documenting in the medical record the patient-directed care plan;

(B) the effectiveness and patient-centeredness of the care plan in organizing delivery of services consistent with the plan;

(C) the availability of the care plan and associated documentation to other providers that care for the beneficiary; and
(D) the extent to which the beneficiary received services and support that is free from discrimination based on advanced age, disability status, or advanced illness.

(7) Stakeholder’s views on how such quality metrics would provide information on—

(A) the goals, values, and preferences of the beneficiary;

(B) the documentation of the care plan;

(C) services furnished to the beneficiary;

and

(D) outcomes of treatment.

(8) Stakeholder’s views on—

(A) the type of training and education needed for applicable providers, individuals, and caregivers in order to facilitate longitudinal comprehensive care planning services;

(B) the types of providers of services and suppliers that should be included in the interdisciplinary team of an applicable provider; and

(C) the characteristics of Medicare beneficiaries that would be most appropriate to receive longitudinal comprehensive care planning services, such as individuals with advanced dis-
case and individuals who need assistance with multiple activities of daily living.

(9) Stakeholder’s views on the frequency with which longitudinal comprehensive care planning services should be furnished.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) DEFINITIONS.—In this section:

(1) APPLICABLE PROVIDER.—The term “applicable provider” means a hospice program (as defined in subsection (dd)(2) of section 1861 of the Social Security Act (42 U.S.C. 1395ww)) or other provider of services (as defined in subsection (u) of such section) or supplier (as defined in subsection (d) of such section) that—

(A) furnishes longitudinal comprehensive care planning services through an interdisciplinary team; and

(B) meets such other requirements as the Secretary may determine to be appropriate.
(2) **Comptroller General.**—The term “Comptroller General” means the Comptroller General of the United States.

(3) **Interdisciplinary Team.**—The term “interdisciplinary team” means a group that—

(A) includes the personnel described in subsection (dd)(2)(B)(i) of such section 1861;

(B) may include a chaplain, minister, or other clergy; and

(C) may include other direct care personnel.

(4) **Longitudinal Comprehensive Care Planning Services.**—The term “longitudinal comprehensive care planning services” means a voluntary shared decisionmaking process that is furnished by an applicable provider through an interdisciplinary team and includes a conversation with Medicare beneficiaries who have received a diagnosis of a serious or life-threatening illness. The purpose of such services is to discuss a longitudinal care plan that addresses the progression of the disease, treatment options, the goals, values, and preferences of the beneficiary, and the availability of other resources and social supports that may reduce the
beneficiary’s health risks and promote self-management and shared decisionmaking.

(5) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

Subtitle F—Other Policies to Improve Care for the Chronically Ill

SEC. 50351. GAO STUDY AND REPORT ON IMPROVING MEDICATION SYNCHRONIZATION.

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall conduct a study on the extent to which Medicare prescription drug plans (MA–PD plans and stand alone prescription drug plans) under part D of title XVIII of the Social Security Act and private payors use programs that synchronize pharmacy dispensing so that individuals may receive multiple prescriptions on the same day to facilitate comprehensive counseling and promote medication adherence. The study shall include a analysis of the following:

(1) The extent to which pharmacies have adopted such programs.

(2) The common characteristics of such programs, including how pharmacies structure counseling sessions under such programs and the types
of payment and other arrangements that Medicare
prescription drug plans and private payors employ
under such programs to support the efforts of phar-
macies.

(3) How such programs compare for Medicare
prescription drug plans and private payors.

(4) What is known about how such programs
affect patient medication adherence and overall pa-
tient health outcomes, including if adherence and
outcomes vary by patient subpopulations, such as
disease state and socioeconomic status.

(5) What is known about overall patient satis-
faction with such programs and satisfaction with
such programs, including within patient subpopula-
tions, such as disease state and socioeconomic sta-
tus.

(6) The extent to which laws and regulations of
the Medicare program support such programs.

(7) Barriers to the use of medication synchroni-
ization programs by Medicare prescription drug
plans.

(b) REPORT.—Not later than 18 months after the
date of the enactment of this Act, the Comptroller General
shall submit to Congress a report containing the results
of the study under subsection (a), together with rec-
omendations for such legislation and administrative ac-
tion as the Comptroller General determines appropriate.

SEC. 50352. GAO STUDY AND REPORT ON IMPACT OF OBE-
SITY DRUGS ON PATIENT HEALTH AND
SPENDING.

(a) Study.—The Comptroller General of the United
States (in this section referred to as the “Comptroller
General”) shall, to the extent data are available, conduct
a study on the use of prescription drugs to manage the
weight of obese patients and the impact of coverage of
such drugs on patient health and on health care spending.
Such study shall examine the use and impact of these obe-
sity drugs in the non-Medicare population and for Medi-
care beneficiaries who have such drugs covered through
an MA–PD plan (as defined in section 1860D–1(a)(3)(C)
of the Social Security Act (42 U.S.C. 1395w–
101(a)(3)(C))) as a supplemental health care benefit. The
study shall include an analysis of the following:

(1) The prevalence of obesity in the Medicare
and non-Medicare population.

(2) The utilization of obesity drugs.

(3) The distribution of Body Mass Index by in-
dividuals taking obesity drugs, to the extent prac-
ticable.
(4) What is known about the use of obesity drugs in conjunction with the receipt of other items or services, such as behavioral counseling, and how these compare to items and services received by obese individuals who do not take obesity drugs.

(5) Physician considerations and attitudes related to prescribing obesity drugs.

(6) The extent to which coverage policies cease or limit coverage for individuals who fail to receive clinical benefit.

(7) What is known about the extent to which individuals who take obesity drugs adhere to the prescribed regimen.

(8) What is known about the extent to which individuals who take obesity drugs maintain weight loss over time.

(9) What is known about the subsequent impact such drugs have on medical services that are directly related to obesity, including with respect to subpopulations determined based on the extent of obesity.

(10) What is known about the spending associated with the care of individuals who take obesity drugs, compared to the spending associated with the care of individuals who do not take such drugs.
(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 50353. HHS STUDY AND REPORT ON LONG-TERM RISK FACTORS FOR CHRONIC CONDITIONS AMONG MEDICARE BENEFICIARIES.

(a) STUDY.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study on long-term cost drivers to the Medicare program, including obesity, tobacco use, mental health conditions, and other factors that may contribute to the deterioration of health conditions among individuals with chronic conditions in the Medicare population. The study shall include an analysis of any barriers to collecting and analyzing such information and how to remove any such barriers (including through legislation and administrative actions).

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study under subsection (a), together with recommendations for such legislation and administrative action as the
Secretary determines appropriate. The Secretary shall also post such report on the Internet website of the Department of Health and Human Services.

SEC. 50354. PROVIDING PRESCRIPTION DRUG PLANS WITH PARTS A AND B CLAIMS DATA TO PROMOTE THE APPROPRIATE USE OF MEDICATIONS AND IMPROVE HEALTH OUTCOMES.

Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

“(6) Providing prescription drug plans with parts A and B claims data to promote the appropriate use of medications and improve health outcomes.—

“(A) Process.—Subject to subparagraph (B), the Secretary shall establish a process under which a PDP sponsor of a prescription drug plan may submit a request for the Secretary to provide the sponsor, on a periodic basis and in an electronic format, beginning in plan year 2020, data described in subparagraph (D) with respect to enrollees in such plan. Such data shall be provided without regard to whether such enrollees are described in clause (ii) of paragraph (2)(A).
“(B) Purposes.—A PDP sponsor may use the data provided to the sponsor pursuant to subparagraph (A) for any of the following purposes:

“(i) To optimize therapeutic outcomes through improved medication use, as such phrase is used in clause (i) of paragraph (2)(A).

“(ii) To improving care coordination so as to prevent adverse health outcomes, such as preventable emergency department visits and hospital readmissions.

“(iii) For any other purpose determined appropriate by the Secretary.

“(C) Limitations on data use.—A PDP sponsor shall not use data provided to the sponsor pursuant to subparagraph (A) for any of the following purposes:

“(i) To inform coverage determinations under this part.

“(ii) To conduct retroactive reviews of medically accepted indications determinations.

“(iii) To facilitate enrollment changes to a different prescription drug plan or an
MA–PD plan offered by the same parent organization.

“(iv) To inform marketing of benefits.

“(v) For any other purpose that the Secretary determines is necessary to include in order to protect the identity of individuals entitled to, or enrolled for, benefits under this title and to protect the security of personal health information.

“(D) DATA DESCRIBED.—The data described in this clause are standardized extracts (as determined by the Secretary) of claims data under parts A and B for items and services furnished under such parts for time periods specified by the Secretary. Such data shall include data as current as practicable.”.
TITLE IV—PART B IMPROVEMENT ACT AND OTHER PART B ENHANCEMENTS
Subtitle A—Medicare Part B Improvement Act

SEC. 50401. HOME INFUSION THERAPY SERVICES TEMPORARY TRANSITIONAL PAYMENT.

(a) In General.—Section 1834(u) of the Social Security Act (42 U.S.C. 1395m(u)) is amended, by adding at the end the following new paragraph:

“(7) HOME INFUSION THERAPY SERVICES TEMPORARY TRANSITIONAL PAYMENT.—

“(A) TEMPORARY TRANSITIONAL PAYMENT.—

“(i) IN GENERAL.—The Secretary shall, in accordance with the payment methodology described in subparagraph (B) and subject to the provisions of this paragraph, provide a home infusion therapy services temporary transitional payment under this part to an eligible home infusion supplier (as defined in subparagraph (F)) for items and services described in subparagraphs (A) and (B) of section 1861(iii)(2)) furnished during the period...
specified in clause (ii) by such supplier in coordination with the furnishing of transitional home infusion drugs (as defined in clause (iii)).

“(ii) PERIOD SPECIFIED.—For purposes of clause (i), the period specified in this clause is the period beginning on January 1, 2019, and ending on the day before the date of the implementation of the payment system under paragraph (1)(A).

“(iii) TRANSITIONAL HOME INFUSION DRUG DEFINED.—For purposes of this paragraph, the term ‘transitional home infusion drug’ has the meaning given to the term ‘home infusion drug’ under section 1861(iii)(3)(C)), except that clause (ii) of such section shall not apply if a drug described in such clause is identified in clauses (i), (ii), (iii) or (iv) of subparagraph (C) as of the date of the enactment of this paragraph.

“(B) PAYMENT METHODOLOGY.—For purposes of this paragraph, the Secretary shall establish a payment methodology, with respect to items and services described in subparagraph
(A)(i). Under such payment methodology the Secretary shall—

“(i) create the three payment categories described in clauses (i), (ii), and (iii) of subparagraph (C);

“(ii) assign drugs to such categories, in accordance with such clauses;

“(iii) assign appropriate Healthcare Common Procedure Coding System (HCPCS) codes to each payment category; and

“(iv) establish a single payment amount for each such payment category, in accordance with subparagraph (D), for each infusion drug administration calendar day in the individual’s home for drugs assigned to such category.

“(C) PAYMENT CATEGORIES.—

“(i) PAYMENT CATEGORY 1.—The Secretary shall create a payment category 1 and assign to such category drugs which are covered under the Local Coverage Determination on External Infusion Pumps (LCD number L33794) and billed with the following HCPCS codes (as identified as of
January 1, 2018, and as subsequently modified by the Secretary): J0133, J0285, J0287, J0288, J0289, J0895, J1170, J1250, J1265, J1325, J1455, J1457, J1570, J2175, J2260, J2270, J2274, J2278, J3010, or J3285.

“(ii) PAYMENT CATEGORY 2.—The Secretary shall create a payment category and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J1555 JB, J1559 JB, J1561 JB, J1562 JB, J1569 JB, or J1575 JB.

“(iii) PAYMENT CATEGORY 3.—The Secretary shall create a payment category and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J9000, J9039, J9040,
J9065, J9100, J9190, J9200, J9360, or J9370.

“(iv) Infusion Drugs Not Otherwise Included.—With respect to drugs that are not included in payment category 1, 2, or 3 under clause (i), (ii), or (iii), respectively, the Secretary shall assign to the most appropriate of such categories, as determined by the Secretary, drugs which are—

“(I) covered under such local coverage determination and billed under HCPCS codes J7799 or J7999 (as identified as of July 1, 2017, and as subsequently modified by the Secretary); or

“(II) billed under any code that is implemented after the date of the enactment of this paragraph and included in such local coverage determination or included in subregulatory guidance as a home infusion drug described in subparagraph (A)(i).

“(D) Payment Amounts.—
“(i) IN GENERAL.—Under the payment methodology, the Secretary shall pay eligible home infusion suppliers, with respect to items and services described in subparagraph (A)(i) furnished during the period described in subparagraph (A)(ii) by such supplier to an individual, at amounts equal to the amounts determined under the physician fee schedule established under section 1848 for services furnished during the year for codes and units of such codes described in clauses (ii), (iii), and (iv) with respect to drugs included in the payment category under subparagraph (C) specified in the respective clause, determined without application of the geographic adjustment under subsection (e) of such section.

“(ii) PAYMENT AMOUNT FOR CATEGORY 1.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 1 described in subparagraph (C)(i), are one unit of HCPCS code 96365 plus three units of HCPCS code 96366 (as
identified as of January 1, 2018, and as subsequently modified by the Secretary).

“(iii) Payment amount for category 2.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 2 described in subparagraph (C)(i), are one unit of HCPCS code 96369 plus three units of HCPCS code 96370 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

“(iv) Payment amount for category 3.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 3 described in subparagraph (C)(i), are one unit of HCPCS code 96413 plus three units of HCPCS code 96415 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

“(E) Clarifications.—

“(i) Infusion drug administration day.—For purposes of this subsection, with respect to the furnishing of transitional home infusion drugs or home infu-
sion drugs to an individual by an eligible
home infusion supplier or a qualified home
infusion therapy supplier, a reference to
payment to such supplier for an infusion
drug administration calendar day in the in-
dividual’s home shall refer to payment only
for the date on which professional services
(as described in section 1861(iii)(2)(A))
were furnished to administer such drugs to
such individual. For purposes of the pre-
vious sentence, an infusion drug adminis-
tration calendar day shall include all such
drugs administered to such individual on
such day.

“(ii) TREATMENT OF MULTIPLE
DRUGS ADMINISTERED ON SAME INFUSION
DRUG ADMINISTRATION DAY.—In the case
that an eligible home infusion supplier,
with respect to an infusion drug adminis-
tration calendar day in an individual’s
home, furnishes to such individual transi-
tional home infusion drugs which are not
all assigned to the same payment category
under subparagraph (C), payment to such
supplier for such infusion drug administra-
tion calendar day in the individual’s home shall be a single payment equal to the amount of payment under this paragraph for the drug, among all such drugs so furnished to such individual during such calendar day, for which the highest payment would be made under this paragraph.

“(F) Eligible home infusion suppliers.—In this paragraph, the term ‘eligible home infusion supplier’ means a supplier that is enrolled under this part as a pharmacy that provides external infusion pumps and external infusion pump supplies and that maintains all pharmacy licensure requirements in the State in which the applicable infusion drugs are administered.

“(G) Implementation.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.”.

(b) Conforming Amendments.—(1) Section 1842(b)(6)(I) of the Social Security Act (42 U.S.C. 1395u(b)(6)(I)) is amended by inserting “or, in the case of items and services described in clause (i) of section 1834(u)(7)(A) furnished to an individual during the pe-
period described in clause (ii) of such section, payment shall
be made to the eligible home infusion therapy supplier”
after “payment shall be made to the qualified home infu-
sion therapy supplier”.

(2) Section 5012(d) of the 21st Century Cures Act
is amended by inserting the following before the period
at the end: “, except that the amendments made by para-
graphs (1) and (2) of subsection (c) shall apply to items
and services furnished on or after January 1, 2019”.

SEC. 50402. ORTHOTIST’S AND PROSTHETIST’S CLINICAL
NOTES AS PART OF THE PATIENT’S MEDICAL
RECORD.

Section 1834(h) of the Social Security Act (42 U.S.C.
1395m(h)) is amended by adding at the end the following
new paragraph:

“(5) Documentation created by orthotists and prosthetists.—For purposes of
determining the reasonableness and medical necessity of orthotics and prosthetics, documentation cre-
ated by an orthotist or prosthetist shall be consid-
ered part of the individual’s medical record to sup-
port documentation created by eligible professionals
described in section 1848(k)(3)(B).”.
SEC. 50403. INDEPENDENT ACCREDITATION FOR DIALYSIS FACILITIES AND ASSURANCE OF HIGH QUALITY SURVEYS.

(a) ACCREDITATION AND SURVEYS.—

(1) IN GENERAL.—Section 1865 of the Social Security Act (42 U.S.C. 1395bb) is amended—

(A) in subsection (a)—

(i) in paragraph (1), in the matter preceding subparagraph (A), by striking “or the conditions and requirements under section 1881(b)”; and

(ii) in paragraph (4), by inserting “(including a renal dialysis facility)” after “facility”; and

(B) by adding at the end the following new subsection:

“(e) With respect to an accreditation body that has received approval from the Secretary under subsection (a)(3)(A) for accreditation of provider entities that are required to meet the conditions and requirements under section 1881(b), in addition to review and oversight authorities otherwise applicable under this title, the Secretary shall (as the Secretary determines appropriate) conduct, with respect to such accreditation body and provider entities, any or all of the following as frequently as is other-
wise required to be conducted under this title with respect to other accreditation bodies or other provider entities:

“(1) Validation surveys referred to in subsection (d).

“(2) Accreditation program reviews (as defined in section 488.8(c) of title 42 of the Code of Federal Regulations, or a successor regulation).

“(3) Performance reviews (as defined in section 488.8(a) of title 42 of the Code of Federal Regulations, or a successor regulation).”.

(2) TIMING FOR ACCEPTANCE OF REQUESTS FROM ACCREDITATION ORGANIZATIONS.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall begin accepting requests from national accreditation bodies for a finding described in section 1865(a)(3)(A) of the Social Security Act (42 U.S.C. 1395bb(a)(3)(A)) for purposes of accrediting provider entities that are required to meet the conditions and requirements under section 1881(b) of such Act (42 U.S.C. 1395rr(b)).

(b) REQUIREMENT FOR TIMING OF SURVEYS OF NEW DIALYSIS FACILITIES.—Section 1881(b)(1) of the Social Security Act (42 U.S.C. 1395rr(b)(1)) is amended by adding at the end the following new sentence: “Begin-
ning 180 days after the date of the enactment of this sentence, an initial survey of a provider of services or a renal dialysis facility to determine if the conditions and requirements under this paragraph are met shall be initiated not later than 90 days after such date on which both the provider enrollment form (without regard to whether such form is submitted prior to or after such date of enactment) has been determined by the Secretary to be complete and the provider’s enrollment status indicates approval is pending the results of such survey.”.

SEC. 50404. MODERNIZING THE APPLICATION OF THE STARK RULE UNDER MEDICARE.

(a) Clarification of the Writing Requirement and Signature Requirement for Arrangements Pursuant to the Stark Rule.—

(1) Writing requirement.—Section 1877(h)(1) of the Social Security Act (42 U.S.C. 1395nn(h)(1)) is amended by adding at the end the following new subparagraph:

“(D) Written requirement clarified.—In the case of any requirement pursuant to this section for a compensation arrangement to be in writing, such requirement shall be satisfied by such means as determined by the Secretary, including by a collection of documents, including contemporaneous docu-
ments evidencing the course of conduct between the parties involved.”.

(2) Signature requirement.—Section 1877(h)(1) of the Social Security Act (42 U.S.C. 1395nn(h)(1)), as amended by paragraph (1), is further amended by adding at the end the following new subparagraph:

“(E) Special rule for signature requirements.—In the case of any requirement pursuant to this section for a compensation arrangement to be in writing and signed by the parties, such signature requirement shall be met if—

“(i) not later than 90 consecutive calendar days immediately following the date on which the compensation arrangement became noncompliant, the parties obtain the required signatures; and

“(ii) the compensation arrangement otherwise complies with all criteria of the applicable exception.”.

(b) Indefinite holdover for lease arrangements and personal services arrangements pursuant to the Stark rule.—Section 1877(e) of the Social Security Act (42 U.S.C. 1395nn(e)) is amended—
(1) in paragraph (1), by adding at the end the following new subparagraph:

“(C) HOLDOVER LEASE ARRANGEMENTS.—In the case of a holdover lease arrangement for the lease of office space or equipment, which immediately follows a lease arrangement described in subparagraph (A) for the use of such office space or subparagraph (B) for the use of such equipment and that expired after a term of at least 1 year, payments made by the lessee to the lessor pursuant to such holdover lease arrangement, if—

“(i) the lease arrangement met the conditions of subparagraph (A) for the lease of office space or subparagraph (B) for the use of equipment when the arrangement expired;

“(ii) the holdover lease arrangement is on the same terms and conditions as the immediately preceding arrangement; and

“(iii) the holdover arrangement continues to satisfy the conditions of subparagraph (A) for the lease of office space or subparagraph (B) for the use of equipment.”; and
(2) in paragraph (3), by adding at the end the following new subparagraph:

“(C) Holdenover personal service arrangement.—In the case of a holdover personal service arrangement, which immediately follows an arrangement described in subparagraph (A) that expired after a term of at least 1 year, remuneration from an entity pursuant to such holdover personal service arrangement, if—

“(i) the personal service arrangement met the conditions of subparagraph (A) when the arrangement expired;

“(ii) the holdover personal service arrangement is on the same terms and conditions as the immediately preceding arrangement; and

“(iii) the holdover arrangement continues to satisfy the conditions of subparagraph (A).”.
Subtitle B—Additional Medicare Provisions

SEC. 50411. MAKING PERMANENT THE REMOVAL OF THE RENTAL CAP FOR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE WITH RESPECT TO SPEECH GENERATING DEVICES.

Section 1834(a)(2)(A)(iv) of the Social Security Act (42 U.S.C. 1395m(a)(2)(A)(iv)) is amended by striking “and before October 1, 2018,”.

SEC. 50412. INCREASED CIVIL AND CRIMINAL PENALTIES AND INCREASED SENTENCES FOR FEDERAL HEALTH CARE PROGRAM FRAUD AND ABUSE.

(a) Increased Civil Money Penalties and Criminal Fines.—

(1) Increased civil money penalties.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(A) in subsection (a), in the matter following paragraph (10)—

(i) by striking “$10,000” and inserting “$20,000” each place it appears;

(ii) by striking “$15,000” and inserting “$30,000”; and

(iii) by striking “$50,000” and inserting “$100,000” each place it appears; and
(B) in subsection (b)—

(i) in paragraph (1), in the flush text following subparagraph (B), by striking “$2,000” and inserting “$5,000”;

(ii) in paragraph (2), by striking “$2,000” and inserting “$5,000”; and

(iii) in paragraph (3)(A)(i), by striking “$5,000” and inserting “$10,000”.

(2) INCREASED CRIMINAL FINES.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amend-
ed—

(A) in subsection (a), in the matter fol-

lowing paragraph (6)—

(i) by striking “$25,000” and insert-
ing “$100,000”; and

(ii) by striking “$10,000” and insert-
ing “$20,000”;)

(B) in subsection (b)—

(i) in paragraph (1), in the flush text following subparagraph (B), by striking “$25,000” and inserting “$100,000”; and

(ii) in paragraph (2), in the flush text following subparagraph (B), by striking “$25,000” and inserting “$100,000”;
(C) in subsection (c), by striking "$25,000" and inserting "$100,000";  

(D) in subsection (d), in the flush text following paragraph (2), by striking "$25,000" and inserting "$100,000"; and  

(E) in subsection (e), by striking "$2,000" and inserting "$4,000".

(b) INCREASED SENTENCES FOR FELONIES INVOLVING FEDERAL HEALTH CARE PROGRAM FRAUD AND ABUSE.—  

(1) FALSE STATEMENTS AND REPRESENTATIONS.—Section 1128B(a) of the Social Security Act (42 U.S.C. 1320a–7b(a)) is amended, in the matter following paragraph (6), by striking "not more than five years or both, or (ii)" and inserting "not more than 10 years or both, or (ii)".  

(2) ANTIKICKBACK.—Section 1128B(b) of such Act (42 U.S.C. 1320a–7b(b)) is amended—  

(A) in paragraph (1), in the flush text following subparagraph (B), by striking "not more than five years" and inserting "not more than 10 years"; and  

(B) in paragraph (2), in the flush text following subparagraph (B), by striking "not more
than five years” and inserting “not more than 10 years”.

(3) False statement or representation with respect to conditions or operations of facilities.—Section 1128B(e) of such Act (42 U.S.C. 1320a–7b(e)) is amended by striking “not more than five years” and inserting “not more than 10 years”.

(4) Excess charges.—Section 1128B(d) of such Act (42 U.S.C. 1320a–7b(d)) is amended, in the flush text following paragraph (2), by striking “not more than five years” and inserting “not more than 10 years”.

(c) Effective date.—The amendments made by this section shall apply to acts committed after the date of the enactment of this Act.

SEC. 50413. REDUCING THE VOLUME OF FUTURE EHR-RELATED SIGNIFICANT HARDSHIP REQUESTS.

Section 1848(o)(2)(A) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)) and section 1886(n)(3)(A) of such Act (42 U.S.C. 1395ww(n)(3)(A)) are each amended in the last sentence by striking “by requiring” and all that follows through “this paragraph”.


SEC. 50414. STRENGTHENING RULES IN CASE OF COMPETITION FOR DIABETIC TESTING STRIPS.

(a) Special Rule in Case of Competition for Diabetic Testing Strips.—

(1) In general.—Paragraph (10) of section 1847(b) of the Social Security Act (42 U.S.C. 1395w–3(b)) is amended—

(A) in subparagraph (A), by striking the second sentence and inserting the following new sentence: “With respect to bids to furnish such types of products on or after January 1, 2019, the volume for such types of products shall be determined by the Secretary through the use of multiple sources of data (from mail order and non-mail order Medicare markets), including market-based data measuring sales of diabetic testing strip products that are not exclusively sold by a single retailer from such markets.”; and

(B) by adding at the end the following new subparagraphs:

“(C) Demonstration of ability to furnish types of diabetic testing strip products.—With respect to bids to furnish diabetic testing strip products on or after January 1, 2019, an entity shall attest to the Sec-
retary that the entity has the ability to obtain
an inventory of the types and quantities of dia-
betic testing strip products that will allow the
entity to furnish such products in a manner
consistent with its bid and—

“(i) demonstrate to the Secretary,
through letters of intent with manufactur-
ers, wholesalers, or other suppliers, or
other evidence as the Secretary may speci-
fy, such ability; or

“(ii) demonstrate to the Secretary
that it made a good faith attempt to obtain
such a letter of intent or such other evi-
dence.

“(D) USE OF UNLISTED TYPES IN CAL-
cULATION OF PERCENTAGE.—With respect to
bids to furnish diabetic testing strip products
on or after January 1, 2019, in determining
under subparagraph (A) whether a bid sub-
mitted by an entity under such subparagraph
covers 50 percent (or such higher percentage as
the Secretary may specify) of all types of dia-
betic testing strip products, the Secretary may
not attribute a percentage to types of diabetic
testing strip products that the Secretary does
not identify by brand, model, and market share volume.

“(E) Adherence to Demonstration.—

“(i) In general.—In the case of an entity that is furnishing diabetic testing strip products on or after January 1, 2019, under a contract entered into under the competition conducted pursuant to paragraph (1), the Secretary shall establish a process to monitor, on an ongoing basis, the extent to which such entity continues to cover the product types included in the entity’s bid.

“(ii) Termination.—If the Secretary determines that an entity described in clause (i) fails to maintain in inventory, or otherwise maintain ready access to (through requirements, contracts, or otherwise) a type of product included in the entity’s bid, the Secretary may terminate such contract unless the Secretary finds that the failure of the entity to maintain inventory of, or ready access to, the product is the result of the discontinuation of the product by the product manufacturer,
a market-wide shortage of the product, or
the introduction of a newer model or
version of the product in the market in-
volved.”.

(b) CODIFYING AND EXPANDING ANTI-SWITCHING
RULE.—Section 1847(b) of the Social Security Act (42
U.S.C. 1395w–3(b)), as amended by subsection (a)(1), is
further amended—

(1) by redesignating paragraph (11) as para-
graph (12); and

(2) by inserting after paragraph (10) the fol-
lowing new paragraph:

“(11) ADDITIONAL SPECIAL RULES IN CASE OF
COMPETITION FOR DIABETIC TESTING STRIPS.—

“(A) IN GENERAL.—With respect to an en-
tity that is furnishing diabetic testing strip
products to individuals under a contract entered
into under the competitive acquisition program
established under this section, the entity shall
furnish to each individual a brand of such prod-
ucts that is compatible with the home blood glu-
cose monitor selected by the individual.

“(B) PROHIBITION ON INFLUENCING AND
INCENTIVIZING.—An entity described in sub-
paragraph (A) may not attempt to influence or
incentivize an individual to switch the brand of glucose monitor or diabetic testing strip product selected by the individual, including by—

“(i) persuading, pressuring, or advising the individual to switch; or

“(ii) furnishing information about alternative brands to the individual where the individual has not requested such information.

“(C) PROVISION OF INFORMATION.—

“(i) STANDARDIZED INFORMATION.—

Not later than January 1, 2019, the Secretary shall develop and make available to entities described in subparagraph (A) standardized information that describes the rights of an individual with respect to such an entity. The information described in the preceding sentence shall include information regarding—

“(I) the requirements established under subparagraphs (A) and (B);

“(II) the right of the individual to purchase diabetic testing strip products from another mail order supplier of such products or a retail phar-
macy if the entity is not able to furnish the brand of such product that is compatible with the home blood glucose monitor selected by the individual; and

“(III) the right of the individual to return diabetic testing strip products furnished to the individual by the entity.

“(ii) REQUIREMENT.—With respect to diabetic testing strip products furnished on or after the date on which the Secretary develops the standardized information under clause (i), an entity described in subparagraph (A) may not communicate directly to an individual until the entity has verbally provided the individual with such standardized information.

“(D) ORDER REFILLS.—With respect to diabetic testing strip products furnished on or after January 1, 2019, the Secretary shall require an entity furnishing diabetic testing strip products to an individual to contact and receive a request from the individual for such products
not more than 14 days prior to dispensing a re-
fill of such products to the individual.”.

(c) IMPLEMENTATION; NON-APPLICATION OF THE
PAPERWORK REDUCTION ACT.—

(1) IMPLEMENTATION.—Notwithstanding any
other provision of law, the Secretary of Health and
Human Services may implement the provisions of,
and amendments made by, this section by program
instruction or otherwise.

(2) NON-APPLICATION OF THE PAPERWORK RE-
DUCTION ACT.—Chapter 35 of title 44, United
States Code (commonly referred to as the “Paper-
work Reduction Act of 1995”), shall not apply to
this section or the amendments made by this section.

TITLE V—OTHER HEALTH
EXTENDERS

SEC. 50501. EXTENSION FOR FAMILY-TO-FAMILY HEALTH
INFORMATION CENTERS.

Section 501(c) of the Social Security Act (42 U.S.C.
701(c)) is amended—

(1) in paragraph (1)(A)—

(A) in clause (v), by striking “and” at the
end;

(B) in clause (vi), by striking the period at
the end and inserting “; and”; and
(C) by adding at the end the following new clause:

“(vii) $6,000,000 for each of fiscal years 2018 and 2019.”;

(2) in paragraph (3)(C), by inserting before the period the following: “, and with respect to fiscal years 2018 and 2019, such centers shall also be developed in all territories and at least one such center shall be developed for Indian tribes”; and

(3) by amending paragraph (5) to read as follows:

“(5) For purposes of this subsection—

“(A) the term ‘Indian tribe’ has the meaning given such term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603);

“(B) the term ‘State’ means each of the 50 States and the District of Columbia; and

“(C) the term ‘territory’ means Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Northern Mariana Islands.”.

SEC. 50502. EXTENSION FOR SEXUAL RISK AVOIDANCE EDUCATION.

(a) In General.—Section 510 of the Social Security Act (42 U.S.C. 710) is amended to read as follows:
“SEC. 510. SEXUAL RISK AVOIDANCE EDUCATION.

“(a) In General.—

“(1) Allotments to States.—For the purpose described in subsection (b), the Secretary shall, for each of fiscal years 2018 and 2019, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

“(A) the amount appropriated pursuant to subsection (e)(1) for the fiscal year, minus the amount reserved under subsection (e)(2) for the fiscal year; and

“(B) the proportion that the number of low-income children in the State bears to the total of such numbers of children for all the States.

“(2) Other Allotments.—

“(A) Other Entities.—For the purpose described in subsection (b), the Secretary shall, for each of fiscal years 2018 and 2019, for any State which has not transmitted an application for the fiscal year under section 505(a), allot to one or more entities in the State the amount that would have been allotted to the State under paragraph (1) if the State had submitted such an application.
“(B) Process.—The Secretary shall select the recipients of allotments under subparagraph (A) by means of a competitive grant process under which—

“(i) not later than 30 days after the deadline for the State involved to submit an application for the fiscal year under section 505(a), the Secretary publishes a notice soliciting grant applications; and

“(ii) not later than 120 days after such deadline, all such applications must be submitted.

“(b) Purpose.—

“(1) In general.—Except for research under paragraph (5) and information collection and reporting under paragraph (6), the purpose of an allotment under subsection (a) to a State (or to another entity in the State pursuant to subsection (a)(2)) is to enable the State or other entity to implement education exclusively on sexual risk avoidance (meaning voluntarily refraining from sexual activity).

“(2) Required components.—Education on sexual risk avoidance pursuant to an allotment under this section shall—
“(A) ensure that the unambiguous and primary emphasis and context for each topic described in paragraph (3) is a message to youth that normalizes the optimal health behavior of avoiding nonmarital sexual activity;

“(B) be medically accurate and complete;

“(C) be age-appropriate;

“(D) be based on adolescent learning and developmental theories for the age group receiving the education; and

“(E) be culturally appropriate, recognizing the experiences of youth from diverse communities, backgrounds, and experiences.

“(3) TOPICS.—Education on sexual risk avoidance pursuant to an allotment under this section shall address each of the following topics:

“(A) The holistic individual and societal benefits associated with personal responsibility, self-regulation, goal setting, healthy decision-making, and a focus on the future.

“(B) The advantage of refraining from nonmarital sexual activity in order to improve the future prospects and physical and emotional health of youth.
“(C) The increased likelihood of avoiding poverty when youth attain self-sufficiency and emotional maturity before engaging in sexual activity.

“(D) The foundational components of healthy relationships and their impact on the formation of healthy marriages and safe and stable families.

“(E) How other youth risk behaviors, such as drug and alcohol usage, increase the risk for teen sex.

“(F) How to resist and avoid, and receive help regarding, sexual coercion and dating violence, recognizing that even with consent teen sex remains a youth risk behavior.

“(4) CONTRACEPTION.—Education on sexual risk avoidance pursuant to an allotment under this section shall ensure that—

“(A) any information provided on contraception is medically accurate and complete and ensures that students understand that contraception offers physical risk reduction, but not risk elimination; and
“(B) the education does not include demonstrations, simulations, or distribution of contraceptive devices.

“(5) RESEARCH.—

“(A) IN GENERAL.—A State or other entity receiving an allotment pursuant to subsection (a) may use up to 20 percent of such allotment to build the evidence base for sexual risk avoidance education by conducting or supporting research.

“(B) REQUIREMENTS.—Any research conducted or supported pursuant to subparagraph (A) shall be—

“(i) rigorous;

“(ii) evidence-based; and

“(iii) designed and conducted by independent researchers who have experience in conducting and publishing research in peer-reviewed outlets.

“(6) INFORMATION COLLECTION AND REPORTING.—A State or other entity receiving an allotment pursuant to subsection (a) shall, as specified by the Secretary—
“(A) collect information on the programs and activities funded through the allotment; and

“(B) submit reports to the Secretary on the data from such programs and activities.

“(c) NATIONAL EVALUATION.—

“(1) IN GENERAL.—The Secretary shall—

“(A) in consultation with appropriate State and local agencies, conduct one or more rigorous evaluations of the education funded through this section and associated data; and

“(B) submit a report to the Congress on the results of such evaluations, together with a summary of the information collected pursuant to subsection (b)(6).

“(2) CONSULTATION.—In conducting the evaluations required by paragraph (1), including the establishment of rigorous evaluation methodologies, the Secretary shall consult with relevant stakeholders and evaluation experts.

“(d) APPLICABILITY OF CERTAIN PROVISIONS.—

“(1) Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(e).
“(2) Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

“(e) DEFINITIONS.—In this section:

“(1) The term ‘age-appropriate’ means 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.

“(2) The term ‘medically accurate and complete’ means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

“(A) published in peer-reviewed journals, where applicable; or

“(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

“(3) The term ‘rigorous’, with respect to research or evaluation, means using—

“(A) established scientific methods for measuring the impact of an intervention or program model in changing behavior (specifically
sexual activity or other sexual risk behaviors),
or reducing pregnancy, among youth; or

“(B) other evidence-based methodologies
established by the Secretary for purposes of this
section.

“(4) The term ‘youth’ refers to one or more in-
dividuals who have attained age 10 but not age 20.

“(f) FUNDING.—

“(1) IN GENERAL.—To carry out this section,
there is appropriated, out of any money in the
Treasury not otherwise appropriated, $75,000,000
for each of fiscal years 2018 and 2019.

“(2) RESERVATION.—The Secretary shall re-
serve, for each of fiscal years 2018 and 2019, not
more than 20 percent of the amount appropriated
pursuant to paragraph (1) for administering the
program under this section, including the conducting
of national evaluations and the provision of technical
assistance to the recipients of allotments.”.

(b) EFFECTIVE DATE.—The amendment made by
this section shall take effect as if enacted on October 1,
2017.
SEC. 50503. EXTENSION FOR PERSONAL RESPONSIBILITY EDUCATION.

(a) IN GENERAL.—Section 513 of the Social Security Act (42 U.S.C. 713) is amended—

(1) in subsection (a)(1)(A), by striking “2017” and inserting “2019”; and

(2) in subsection (a)(4)—

(A) in subparagraph (A), by striking “2017” each place it appears and inserting “2019”; and

(B) in subparagraph (B)—

(i) in the subparagraph heading, by striking “3-YEAR GRANTS” and inserting “COMPETITIVE PREP GRANTS”; and

(ii) in clause (i), by striking “solicit applications to award 3-year grants in each of fiscal years 2012 through 2017” and inserting “continue through fiscal year 2019 grants awarded for any of fiscal years 2015 through 2017”;

(3) in subsection (c)(1), by inserting after “youth with HIV/AIDS,” the following: “victims of human trafficking,”; and

(4) in subsection (f), by striking “2017” and inserting “2019”.
(b) **Effective Date.**—The amendments made by this section shall take effect as if enacted on October 1, 2017.

**TITLE VI—CHILD AND FAMILY SERVICES AND SUPPORTS EXTENDERS**

Subtitle A—Continuing the Maternal, Infant, and Early Childhood Home Visiting Program

**SEC. 50601. CONTINUING EVIDENCE-BASED HOME VISITING PROGRAM.**

Section 511(j)(1)(H) of the Social Security Act (42 U.S.C. 711(j)(1)(H)) is amended by striking “fiscal year 2017” and inserting “each of fiscal years 2017 through 2022”.

**SEC. 50602. CONTINUING TO DEMONSTRATE RESULTS TO HELP FAMILIES.**

(a) **Require Service Delivery Models To Demonstrate Improvement In Applicable Benchmark Areas.**—Section 511 of the Social Security Act (42 U.S.C. 711) is amended in each of subsections (d)(1)(A) and (h)(4)(A) by striking “each of”.

(b) **Demonstration of Improvements in Subsequent Years.**—Section 511(d)(1) of such Act (42 U.S.C. 711(d)(1)) is amended by adding at the end the following:
“(D) Demonstration of improvements in subsequent years.—

“(i) Continued measurement of improvement in applicable benchmark areas.—The eligible entity, after demonstrating improvements for eligible families as specified in subparagraphs (A) and (B), shall continue to track and report, not later than 30 days after the end of fiscal year 2020 and every 3 years thereafter, information demonstrating that the program results in improvements for the eligible families participating in the program in at least 4 of the areas specified in subparagraph (A) that the service delivery model or models selected by the entity are intended to improve.

“(ii) Corrective action plan.—If the eligible entity fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), as compared to eligible families who do not receive services under an early childhood home visitation program, the entity shall develop and implement a plan to improve outcomes in
each of the areas specified in subparagraph (A) that the service delivery model or models selected by the entity are intended to improve, subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

“(iii) Technical Assistance.—The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

“(iv) No Improvement or Failure to Submit Report.—If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (ii) has failed to demonstrate any improve-
ment in at least 4 of the areas specified in
subparagraph (A), or if the Secretary de-
termines that an eligible entity has failed
to submit the report required by clause (i),
the Secretary shall terminate the grant
made to the entity under this section and
may include any unexpended grant funds
in grants made to nonprofit organizations
under subsection (h)(2)(B).”.

(c) Including Information On Applicable
Benchmarks In Application.—Section 511(e)(5) of
such Act (42 U.S.C. 711(e)(5)) is amended by inserting
“that the service delivery model or models selected by the
entity are intended to improve” before the period at the
end.

SEC. 50603. REVIEWING STATEWIDE NEEDS TO TARGET RE-
SOURCES.

Section 511(b)(1) of the Social Security Act (42
U.S.C. 711(b)(1)) is amended by striking “Not later
than” and all that follows through “section 505(a)” and
inserting “Each State shall, as a condition of receiving
payments from an allotment for the State under section
502, conduct a statewide needs assessment (which may be
separate from but in coordination with the statewide needs
assessment required under section 505(a) and which shall
be reviewed and updated by the State not later than October 1, 2020”.

SEC. 50604. IMPROVING THE LIKELIHOOD OF SUCCESS IN HIGH-RISK COMMUNITIES.

Section 511(d)(4)(A) of the Social Security Act (42 U.S.C. 711(d)(4)(A)) is amended by inserting “, taking into account the staffing, community resource, and other requirements to operate at least one approved model of home visiting and demonstrate improvements for eligible families” before the period.

SEC. 50605. OPTION TO FUND EVIDENCE-BASED HOME VISITING ON A PAY FOR OUTCOME BASIS.

(a) In General.—Section 511(c) of the Social Security Act (42 U.S.C. 711(c)) is amended by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively, and by inserting after paragraph (2) the following:

“(3) Authority to use grant for a pay for outcomes initiative.—An eligible entity to which a grant is made under paragraph (1) may use up to 25 percent of the grant for outcomes or success payments related to a pay for outcomes initiative that will not result in a reduction of funding for services delivered by the entity under a childhood home visitation program under this section while the
eligible entity develops or operates such an initia-
tive.”.

(b) **DEFINITION OF PAY FOR OUTCOMES INITIA-
TIVE.**—Section 511(k) of such Act (42 U.S.C. 711(k)) is
amended by adding at the end the following:

“(4) **PAY FOR OUTCOMES INITIATIVE.**—The
term ‘pay for outcomes initiative’ means a perform-
ance-based grant, contract, cooperative agreement,
or other agreement awarded by a public entity in
which a commitment is made to pay for improved
outcomes achieved as a result of the intervention
that result in social benefit and direct cost savings
or cost avoidance to the public sector. Such an ini-
tiative shall include—

“(A) a feasibility study that describes how
the proposed intervention is based on evidence
of effectiveness;

“(B) a rigorous, third-party evaluation
that uses experimental or quasi-experimental
design or other research methodologies that
allow for the strongest possible causal infer-
ences to determine whether the initiative has
met its proposed outcomes as a result of the
intervention;
“(C) an annual, publicly available report on the progress of the initiative; and

“(D) 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 shall not apply with respect to payments to a third party conducting the evaluation described in subparagraph (B).”.

(c) Extended Availability of Funds.—Section 511(j)(3) of such Act (42 U.S.C. 711(j)(3)) is amended—

(1) by striking “(3) Availability.—Funds” and inserting the following:

“(3) Availability.—

“(A) In general.—Except as provided in subparagraph (B), funds”; and

(2) by adding at the end the following:

“(B) Funds for Pay for Outcomes Initiatives.—Funds made available to an eligible entity under this section for a fiscal year (or portion of a fiscal year) for a pay for outcomes initiative shall remain available for expenditure by the eligible entity for not more than 10 years after the funds are so made available.”. 
SEC. 50606. DATA EXCHANGE STANDARDS FOR IMPROVED INTEROPERABILITY.

(a) In General.—Section 511(h) of the Social Security Act (42 U.S.C. 711(h)) is amended by adding at the end the following:

“(5) Data exchange standards for improved interoperability.—

“(A) Designation and use of data exchange standards.—

“(i) Designation.—The head of the department or agency responsible for administering a program funded under this section shall, in consultation with an inter-agency work group established by the Office of Management and Budget and considering State government perspectives, designate data exchange standards for necessary categories of information that a State agency operating the program is required to electronically exchange with another State agency under applicable Federal law.

“(ii) Data exchange standards must be nonproprietary and interoperable.—The data exchange standards designated under clause (i) shall, to the ex-
tent practicable, be nonproprietary and interoperable.

“(iii) OTHER REQUIREMENTS.—In designating data exchange standards under this paragraph, the Secretary shall, to the extent practicable, incorporate—

“(I) interoperable standards developed and maintained by an international voluntary consensus standards body, as defined by the Office of Management and Budget;

“(II) interoperable standards developed and maintained by intergovernmental partnerships, such as the National Information Exchange Model; and

“(III) interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance.

“(B) DATA EXCHANGE STANDARDS FOR FEDERAL REPORTING.—

“(i) DESIGNATION.—The head of the department or agency responsible for administering a program referred to in this
section shall, in consultation with an inter-
agency work group established by the Of-
vice of Management and Budget, and con-
sidering State government perspectives,
designate data exchange standards to gov-
ern Federal reporting and exchange re-
quirements under applicable Federal law.

“(ii) REQUIREMENTS.—The data ex-
change reporting standards required by
clause (i) shall, to the extent practicable—

“(I) incorporate a widely accept-
ed, nonproprietary, searchable, com-
puter-readable format;

“(II) be consistent with and im-
plement applicable accounting prin-
ciples;

“(III) be implemented in a man-
ner that is cost-effective and improves
program efficiency and effectiveness;

“(IV) be capable of being contin-
ually upgraded as necessary.

“(iii) INCORPORATION OF NONPROPR-
ETARY STANDARDS.—In designating data
exchange standards under this paragraph,
the Secretary shall, to the extent practicable, incorporate existing nonproprietary standards, such as the eXtensible Mark up Language.

“(iv) Rule of Construction.—Nothing in this paragraph shall be construed to require a change to existing data exchange standards for Federal reporting about a program referred to in this section, if the head of the department or agency responsible for administering the program finds the standards to be effective and efficient.”.

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date that is 2 years after the date of enactment of this Act.

SEC. 50607. ALLOCATION OF FUNDS.

Section 511(j) of the Social Security Act (42 U.S.C. 711(j)) is amended by adding at the end the following:

“(4) Allocation of Funds.—To the extent that the grant amount awarded under this section to an eligible entity is determined on the basis of relative population or poverty considerations, the Secretary shall make the determination using the most
accurate Federal data available for the eligible entity.”.

Subtitle B—Extension of Health Professions Workforce Demonstration Projects

SEC. 50611. EXTENSION OF HEALTH WORKFORCE DEMONSTRATION PROJECTS FOR LOW-INCOME INDIVIDUALS.

Section 2008(c)(1) of the Social Security Act (42 U.S.C. 1397g(c)(1)) is amended by striking “2017” and inserting “2019”.

TITLE VII—FAMILY FIRST PREVENTION SERVICES ACT

Subtitle A—Investing in Prevention and Supporting Families

SEC. 50701. SHORT TITLE.

This subtitle may be cited as the “Family First Prevention Services Act”.

SEC. 50702. PURPOSE.

The purpose of this subtitle is to enable States to use Federal funds available under parts B and E of title IV of the Social Security Act to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home
PART I—PREVENTION ACTIVITIES UNDER TITLE IV–E

SEC. 50711. FOSTER CARE PREVENTION SERVICES AND PROGRAMS.

(a) STATE OPTION.—Section 471 of the Social Security Act (42 U.S.C. 671) is amended—

(1) in subsection (a)(1), by striking “and” and all that follows through the semicolon and inserting “, adoption assistance in accordance with section 473, and, at the option of the State, services or programs specified in subsection (e)(1) of this section for children who are candidates for foster care or who are pregnant or parenting foster youth and the parents or kin caregivers of the children, in accordance with the requirements of that subsection;”; and

(2) by adding at the end the following:

“(e) PREVENTION AND FAMILY SERVICES AND PROGRAMS.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary may make a payment to a State for providing the following services or programs for a child described in paragraph (2) and the parents or kin caregivers of
the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care:

“(A) MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES.—Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) with respect to the child.

“(B) IN-HOME PARENT SKILL-BASED PROGRAMS.—In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) with respect to the child and that include parenting skills training, parent education, and individual and family counseling.

“(2) CHILD DESCRIBED.—For purposes of paragraph (1), a child described in this paragraph is the following:

“(A) A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement
with receipt of services or programs specified in paragraph (1).

“(B) A child in foster care who is a pregnant or parenting foster youth.

“(3) DATE DESCRIBED.—For purposes of paragraph (1), the dates described in this paragraph are the following:

“(A) The date on which a child is identified in a prevention plan maintained under paragraph (4) as a child who is a candidate for foster care (as defined in section 475(13)).

“(B) The date on which a child is identified in a prevention plan maintained under paragraph (4) as a pregnant or parenting foster youth in need of services or programs specified in paragraph (1).

“(4) REQUIREMENTS RELATED TO PROVIDING SERVICES AND PROGRAMS.—Services and programs specified in paragraph (1) may be provided under this subsection only if specified in advance in the child’s prevention plan described in subparagraph (A) and the requirements in subparagraphs (B) through (E) are met:

“(A) PREVENTION PLAN.—The State maintains a written prevention plan for the
child that meets the following requirements (as applicable):

“(i) CANDIDATES.—In the case of a child who is a candidate for foster care described in paragraph (2)(A), the prevention plan shall—

“(I) identify the foster care prevention strategy for the child so that the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver;

“(II) list the services or programs to be provided to or on behalf of the child to ensure the success of that prevention strategy; and

“(III) comply with such other requirements as the Secretary shall establish.

“(ii) PREGNANT OR PARENTING FOSTER YOUTH.—In the case of a child who is a pregnant or parenting foster youth described in paragraph (2)(B), the prevention plan shall—
“(I) be included in the child’s case plan required under section 475(1);

“(II) list the services or programs to be provided to or on behalf of the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent;

“(III) describe the foster care prevention strategy for any child born to the youth; and

“(IV) comply with such other requirements as the Secretary shall establish.

“(B) TRAUMA-INFORMED.—The services or programs to be provided to or on behalf of a child are provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific
interventions to address trauma’s consequences and facilitate healing.

“(C) Only services and programs provided in accordance with promising, supported, or well-supported practices permitted.—

“(i) In general.—Only State expenditures for services or programs specified in subparagraph (A) or (B) of paragraph (1) that are provided in accordance with practices that meet the requirements specified in clause (ii) of this subparagraph and that meet the requirements specified in clause (iii), (iv), or (v), respectively, for being a promising, supported, or well-supported practice, shall be eligible for a Federal matching payment under section 474(a)(6)(A).

“(ii) General practice requirements.—The general practice requirements specified in this clause are the following:

“(I) The practice has a book, manual, or other available writings that specify the components of the
practice protocol and describe how to administer the practice.

“(II) There is no empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

“(III) If multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice.

“(IV) Outcome measures are reliable and valid, and are administered consistently and accurately across all those receiving the practice.

“(V) There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent.

“(iii) Promising Practice.—A practice shall be considered to be a ‘promising practice’ if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of
important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that—

“(I) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; and

“(II) utilized some form of control (such as an untreated group, a placebo group, or a wait list study).

“(iv) SUPPORTED PRACTICE.—A practice shall be considered to be a ‘supported practice’ if—

“(I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the re-
sults or outcomes of at least one study that—

“(aa) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;

“(bb) was a rigorous random-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design); and

“(cc) was carried out in a usual care or practice setting; and

“(II) the study described in sub-clause (I) established that the practice has a sustained effect (when compared to a control group) for at least 6 months beyond the end of the treatment.

“(v) WELL-SUPPORTED PRACTICE.—A practice shall be considered to be a ‘well-supported practice’ if—
“(I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two studies that—

“(aa) were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;

“(bb) were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design); and

“(cc) were carried out in a usual care or practice setting; and
“(II) at least one of the studies described in subclause (I) established that the practice has a sustained effect (when compared to a control group) for at least 1 year beyond the end of treatment.

“(D) GUIDANCE ON PRACTICES CRITERIA AND PRE-APPROVED SERVICES AND PROGRAMS.—

“(i) IN GENERAL.—Not later than October 1, 2018, the Secretary shall issue guidance to States regarding the practices criteria required for services or programs to satisfy the requirements of subparagraph (C). The guidance shall include a pre-approved list of services and programs that satisfy the requirements.

“(ii) UPDATES.—The Secretary shall issue updates to the guidance required by clause (i) as often as the Secretary determines necessary.

“(E) OUTCOME ASSESSMENT AND REPORTING.—The State shall collect and report to the Secretary the following information with respect to each child for whom, or on whose behalf
mental health and substance abuse prevention and treatment services or in-home parent skill-based programs are provided during a 12-month period beginning on the date the child is determined by the State to be a child described in paragraph (2):

“(i) The specific services or programs provided and the total expenditures for each of the services or programs.

“(ii) The duration of the services or programs provided.

“(iii) In the case of a child described in paragraph (2)(A), the child’s placement status at the beginning, and at the end, of the 1-year period, respectively, and whether the child entered foster care within 2 years after being determined a candidate for foster care.

“(5) STATE PLAN COMPONENT.—

“(A) IN GENERAL.—A State electing to provide services or programs specified in paragraph (1) shall submit as part of the State plan required by subsection (a) a prevention services and programs plan component that meets the requirements of subparagraph (B).
“(B) PREVENTION SERVICES AND PROGRAMS PLAN COMPONENT.—In order to meet the requirements of this subparagraph, a prevention services and programs plan component, with respect to each 5-year period for which the plan component is in operation in the State, shall include the following:

“(i) How providing services and programs specified in paragraph (1) is expected to improve specific outcomes for children and families.

“(ii) How the State will monitor and oversee the safety of children who receive services and programs specified in paragraph (1), including through periodic risk assessments throughout the period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph (4) for the provision of the services or programs if the State determines the risk of the child entering foster care remains high despite the provision of the services or programs.
“(iii) With respect to the services and programs specified in subparagraphs (A) and (B) of paragraph (1), information on the specific promising, supported, or well-supported practices the State plans to use to provide the services or programs, including a description of—

“(I) the services or programs and whether the practices used are promising, supported, or well-supported;

“(II) how the State plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices;

“(III) how the State selected the services or programs;

“(IV) the target population for the services or programs; and
“(V) how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary.

“(iv) A description of the consultation that the State agencies responsible for administering the State plans under this part and part B engage in with other State agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph (2) and their parents or kin caregivers.

“(v) A description of how the State shall assess children and their parents or kin caregivers to determine eligibility for services or programs specified in paragraph (1).
“(vi) A description of how the services or programs specified in paragraph (1) that are provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the State plans in effect under subparts 1 and 2 of part B.

“(vii) Descriptions of steps the State is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including—

“(I) ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well-supported practice models selected; and

“(II) developing appropriate prevention plans, and conducting the risk assessments required under clause (iii).

“(viii) A description of how the State will provide training and support for case-
workers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services.

“(ix) A description of how caseload size and type for prevention caseworkers will be determined, managed, and overseen.

“(x) An assurance that the State will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph (1), including information and data necessary to determine the performance measures for the State under paragraph (6) and compliance with paragraph (7).

“(C) REIMBURSEMENT FOR SERVICES UNDER THE PREVENTION PLAN COMPONENT.—

“(i) LIMITATION.—Except as provided in subclause (ii), a State may not receive a Federal payment under this part for a given promising, supported, or well-sup-
ported practice unless (in accordance with subparagraph (B)(iii)(V)) the plan includes a well-designed and rigorous evaluation strategy for that practice.

“(ii) WAIVER OF LIMITATION.—The Secretary may waive the requirement for a well-designed and rigorous evaluation of any well-supported practice if the Secretary deems the evidence of the effectiveness of the practice to be compelling and the State meets the continuous quality improvement requirements included in subparagraph (B)(iii)(II) with regard to the practice.

“(6) PREVENTION SERVICES MEASURES.—

“(A) ESTABLISHMENT; ANNUAL UPDATES.—Beginning with fiscal year 2021, and annually thereafter, the Secretary shall establish the following prevention services measures based on information and data reported by States that elect to provide services and programs specified in paragraph (1):

“(i) PERCENTAGE OF CANDIDATES FOR FOSTER CARE WHO DO NOT ENTER

FOSTER CARE.—The percentage of can-
didates for foster care for whom, or on whose behalf, the services or programs are provided who do not enter foster care, including those placed with a kin caregiver outside of foster care, during the 12-month period in which the services or programs are provided and through the end of the succeeding 12-month period.

“(ii) **PER-CHILD SPENDING.**—The total amount of expenditures made for mental health and substance abuse prevention and treatment services or in-home parent skill-based programs, respectively, for, or on behalf of, each child described in paragraph (2).

“(B) **DATA.**—The Secretary shall establish and annually update the prevention services measures—

“(i) based on the median State values of the information reported under each clause of subparagraph (A) for the 3 then most recent years; and

“(ii) taking into account State differences in the price levels of consumption goods and services using the most recent
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regional price parities published by the Bureau of Economic Analysis of the Department of Commerce or such other data as the Secretary determines appropriate.

“(C) PUBLICATION OF STATE PREVENTION SERVICES MEASURES.—The Secretary shall annually make available to the public the prevention services measures of each State.

“(7) MAINTENANCE OF EFFORT FOR STATE FOSTER CARE PREVENTION EXPENDITURES.—

“(A) IN GENERAL.—If a State elects to provide services and programs specified in paragraph (1) for a fiscal year, the State foster care prevention expenditures for the fiscal year shall not be less than the amount of the expenditures for fiscal year 2014 (or, at the option of a State described in subparagraph (E), fiscal year 2015 or fiscal year 2016 (whichever the State elects)).

“(B) STATE FOSTER CARE PREVENTION EXPENDITURES.—The term ‘State foster care prevention expenditures’ means the following:

“(i) TANF; IV–B; SSBG.—State expenditures for foster care prevention services and activities under the State program
funded under part A (including from amounts made available by the Federal Government), under the State plan developed under part B (including any such amounts), or under the Social Services Block Grant Programs under subtitle A of title XX (including any such amounts).

“(ii) Other state programs.—
State expenditures for foster care prevention services and activities under any State program that is not described in clause (i) (other than any State expenditures for foster care prevention services and activities under the State program under this part (including under a waiver of the program)).

“(C) State expenditures.—The term ‘State expenditures’ means all State or local funds that are expended by the State or a local agency including State or local funds that are matched or reimbursed by the Federal Government and State or local funds that are not matched or reimbursed by the Federal Government.
“(D) Determination of Prevention Services and Activities.—The Secretary shall require each State that elects to provide services and programs specified in paragraph (1) to report the expenditures specified in subparagraph (B) for fiscal year 2014 and for such fiscal years thereafter as are necessary to determine whether the State is complying with the maintenance of effort requirement in subparagraph (A). The Secretary shall specify the specific services and activities under each program referred to in subparagraph (B) that are ‘prevention services and activities’ for purposes of the reports.

“(E) State Described.—For purposes of subparagraph (A), a State is described in this subparagraph if the population of children in the State in 2014 was less than 200,000 (as determined by the United States Census Bureau).

“(8) Prohibition Against Use of State Foster Care Prevention Expenditures and Federal IV–E Prevention Funds for Matching or Expenditure Requirement.—A State that elects to provide services and programs specified in paragraph (1) shall not use any State foster care preven-
tion expenditures for a fiscal year for the State share of expenditures under section 474(a)(6) for a fiscal year.

“(9) ADMINISTRATIVE COSTS.—Expenditures described in section 474(a)(6)(B)—

“(A) shall not be eligible for payment under subparagraph (A), (B), or (E) of section 474(a)(3); and

“(B) shall be eligible for payment under section 474(a)(6)(B) without regard to whether the expenditures are incurred on behalf of a child who is, or is potentially, eligible for foster care maintenance payments under this part.

“(10) APPLICATION.—

“(A) IN GENERAL.—The provision of services or programs under this subsection to or on behalf of a child described in paragraph (2) shall not be considered to be receipt of aid or assistance under the State plan under this part for purposes of eligibility for any other program established under this Act.

“(B) CANDIDATES IN KINSHIP CARE.—A child described in paragraph (2) for whom such services or programs under this subsection are provided for more than 6 months while in the
home of a kin caregiver, and who would satisfy
the AFDC eligibility requirement of section
472(a)(3)(A)(ii)(II) but for residing in the
home of the caregiver for more than 6 months,
is deemed to satisfy that requirement for pur-
poses of determining whether the child is eligi-
ble for foster care maintenance payments under
section 472.”).

(b) DEFINITION.—Section 475 of such Act (42
U.S.C. 675) is amended by adding at the end the fol-
lowing:

“(13) The term ‘child who is a candidate for
foster care’ means, a child who is identified in a pre-
vention plan under section 471(e)(4)(A) as being at
imminent risk of entering foster care (without re-
gard to whether the child would be eligible for foster
care maintenance payments under section 472 or is
or would be eligible for adoption assistance or kin-
ship guardianship assistance payments under section
473) but who can remain safely in the child’s home
or in a kinship placement as long as services or pro-
grams specified in section 471(e)(1) that are nec-
essary to prevent the entry of the child into foster
care are provided. The term includes a child whose
adoption or guardianship arrangement is at risk of
a disruption or dissolution that would result in a foster care placement.”.

(c) PAYMENTS UNDER TITLE IV–E.—Section 474(a) of such Act (42 U.S.C. 674(a)) is amended—

(1) in paragraph (5), by striking the period at the end and inserting “; plus”; and

(2) by adding at the end the following:

“(6) subject to section 471(e)—

“(A) for each quarter—

“(i) subject to clause (ii)—

“(I) beginning after September 30, 2019, and before October 1, 2026, an amount equal to 50 percent of the total amount expended during the quarter for the provision of services or programs specified in subparagraph (A) or (B) of section 471(e)(1) that are provided in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 471(e)(4)(C); and

“(II) beginning after September 30, 2026, an amount equal to the Federal medical assistance percentage
(which shall be as defined in section 1905(b), in the case of a State other than the District of Columbia, or 70 percent, in the case of the District of Columbia) of the total amount expended during the quarter for the provision of services or programs specified in subparagraph (A) or (B) of section 471(e)(1) that are provided in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 471(e)(4)(C) (or, with respect to the payments made during the quarter under a cooperative agreement or contract entered into by the State and an Indian tribe, tribal organization, or tribal consortium for the administration or payment of funds under this part, an amount equal to the Federal medical assistance percentage that would apply under section 479B(d) (in this paragraph referred to as the ‘tribal FMAP’) if the Indian tribe, tribal or-
ganization, or tribal consortium made
the payments under a program oper-
ated under that section, unless the
tribal FMAP is less than the Federal
medical assistance percentage that ap-
plies to the State); except that
“(ii) not less than 50 percent of the
total amount expended by a State under
time clause (i) for a fiscal year shall be for the
 provision of services or programs specified
in subparagraph (A) or (B) of section
471(e)(1) that are provided in accordance
with well-supported practices; plus
“(B) for each quarter specified in subpara-
graph (A), an amount equal to the sum of the
following proportions of the total amount ex-
pended during the quarter—
“(i) 50 percent of so much of the ex-
penditures as are found necessary by the
Secretary for the proper and efficient ad-
ministration of the State plan for the pro-
vision of services or programs specified in
section 471(e)(1), including expenditures
for activities approved by the Secretary
that promote the development of necessary
processes and procedures to establish and implement the provision of the services and programs for individuals who are eligible for the services and programs and expenditures attributable to data collection and reporting; and

“(ii) 50 percent of so much of the expenditures with respect to the provision of services and programs specified in section 471(e)(1) as are for training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision and of the members of the staff of State-licensed or State-approved child welfare agencies providing services to children described in section 471(e)(2) and their parents or kin caregivers, including on how to determine who are individuals eligible for the services or programs, how to identify and provide appropriate services and programs, and how to oversee and evaluate the ongoing appropriateness of the services and programs.”.
(d) TECHNICAL ASSISTANCE AND BEST PRACTICES, CLEARINGHOUSE, AND DATA COLLECTION AND EVALUATIONS.—Section 476 of such Act (42 U.S.C. 676) is amended by adding at the end the following:

"(d) TECHNICAL ASSISTANCE AND BEST PRACTICES, CLEARINGHOUSE, DATA COLLECTION, AND EVALUATIONS RELATING TO PREVENTION SERVICES AND PROGRAMS.—

"(1) TECHNICAL ASSISTANCE AND BEST PRACTICES.—The Secretary shall provide to States and, as applicable, to Indian tribes, tribal organizations, and tribal consortia, technical assistance regarding the provision of services and programs described in section 471(e)(1) and shall disseminate best practices with respect to the provision of the services and programs, including how to plan and implement a well-designed and rigorous evaluation of a promising, supported, or well-supported practice.

"(2) CLEARINGHOUSE OF PROMISING, SUPPORTED, AND WELL-SUPPORTED PRACTICES.—The Secretary shall, directly or through grants, contracts, or interagency agreements, evaluate research on the practices specified in clauses (iii), (iv), and (v), respectively, of section 471(e)(4)(C), and programs that meet the requirements described in section 427(a)(1), including culturally specific, or
location- or population-based adaptations of the practices, to identify and establish a public clearing-house of the practices that satisfy each category described by such clauses. In addition, the clearing-house shall include information on the specific outcomes associated with each practice, including whether the practice has been shown to prevent child abuse and neglect and reduce the likelihood of foster care placement by supporting birth families and kinship families and improving targeted supports for pregnant and parenting youth and their children.

“(3) DATA COLLECTION AND EVALUATIONS.—The Secretary, directly or through grants, contracts, or interagency agreements, may collect data and conduct evaluations with respect to the provision of services and programs described in section 471(e)(1) for purposes of assessing the extent to which the provision of the services and programs—

“(A) reduces the likelihood of foster care placement;

“(B) increases use of kinship care arrangements; or

“(C) improves child well-being.

“(4) REPORTS TO CONGRESS.—
“(A) IN GENERAL.—The Secretary shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives periodic reports based on the provision of services and programs described in section 471(e)(1) and the activities carried out under this subsection.

“(B) PUBLIC AVAILABILITY.—The Secretary shall make the reports to Congress submitted under this paragraph publicly available.

“(5) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary $1,000,000 for fiscal year 2018 and each fiscal year thereafter to carry out this subsection.”.

(e) APPLICATION TO PROGRAMS OPERATED BY INDIAN TRIBAL ORGANIZATIONS.—

(1) IN GENERAL.—Section 479B of such Act (42 U.S.C. 679c) is amended—

(A) in subsection (e)(1)—

(i) in subparagraph (C)(i)—

(I) in subclause (II), by striking “and” after the semicolon;
(II) in subclause (III), by striking the period at the end and inserting “; and”; and

(III) by adding at the end the following:

“(IV) at the option of the tribe, organization, or consortium, services and programs specified in section 471(e)(1) to children described in section 471(e)(2) and their parents or kin caregivers, in accordance with section 471(e) and subparagraph (E).”;

and

(ii) by adding at the end the following:

“(E) PREVENTION SERVICES AND PROGRAMS FOR CHILDREN AND THEIR PARENTS AND KIN CAREGIVERS.—

“(i) IN GENERAL.—In the case of a tribe, organization, or consortium that elects to provide services and programs specified in section 471(e)(1) to children described in section 471(e)(2) and their parents or kin caregivers under the plan, the Secretary shall specify the require-
ments applicable to the provision of the services and programs. The requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to States under section 471(e) and shall permit the provision of the services and programs in the form of services and programs that are adapted to the culture and context of the tribal communities served.

“(ii) PERFORMANCE MEASURES.—The Secretary shall establish specific performance measures for each tribe, organization, or consortium that elects to provide services and programs specified in section 471(e)(1). The performance measures shall, to the greatest extent practicable, be consistent with the prevention services measures required for States under section 471(e)(6) but shall allow for consideration of factors unique to the provision of the services by tribes, organizations, or consortia.”; and

(B) in subsection (d)(1), by striking “and (5)” and inserting “(5), and (6)(A)”.
(2) CONFORMING AMENDMENT.—The heading for subsection (d) of section 479B of such Act (42 U.S.C. 679c) is amended by striking “FOR FOSTER CARE MAINTENANCE AND ADOPTION ASSISTANCE PAYMENTS”.

(f) APPLICATION TO PROGRAMS OPERATED BY TERRITORIES.—Section 1108(a)(2) of the Social Security Act (42 U.S.C. 1308(a)(2)) is amended by striking “or 413(f)” and inserting “413(f), or 474(a)(6)”.

SEC. 50712. FOSTER CARE MAINTENANCE PAYMENTS FOR CHILDREN WITH PARENTS IN A LICENSED RESIDENTIAL FAMILY-BASED TREATMENT FACILITY FOR SUBSTANCE ABUSE.

(a) IN GENERAL.—Section 472 of the Social Security Act (42 U.S.C. 672) is amended—

(1) in subsection (a)(2)(C), by striking “or” and inserting “, with a parent residing in a licensed residential family-based treatment facility, but only to the extent permitted under subsection (j), or in a”; and

(2) by adding at the end the following:

“(j) CHILDREN PLACED WITH A PARENT RESIDING IN A LICENSED RESIDENTIAL FAMILY-BASED TREATMENT FACILITY FOR SUBSTANCE ABUSE.—”
“(1) IN GENERAL.—Notwithstanding the preceding provisions of this section, a child who is eligible for foster care maintenance payments under this section, or who would be eligible for the payments if the eligibility were determined without regard to paragraphs (1)(B) and (3) of subsection (a), shall be eligible for the payments for a period of not more than 12 months during which the child is placed with a parent who is in a licensed residential family-based treatment facility for substance abuse, but only if—

“(A) the recommendation for the placement is specified in the child’s case plan before the placement;

“(B) the treatment facility provides, as part of the treatment for substance abuse, parenting skills training, parent education, and individual and family counseling; and

“(C) the substance abuse treatment, parenting skills training, parent education, and individual and family counseling is provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recog-
nized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing.

“(2) APPLICATION.—With respect to children for whom foster care maintenance payments are made under paragraph (1), only the children who satisfy the requirements of paragraphs (1)(B) and (3) of subsection (a) shall be considered to be children with respect to whom foster care maintenance payments are made under this section for purposes of subsection (h) or section 473(b)(3)(B).”.

(b) CONFORMING AMENDMENT.—Section 474(a)(1) of such Act (42 U.S.C. 674(a)(1)) is amended by inserting “subject to section 472(j),” before “an amount equal to the Federal” the first place it appears.

SEC. 50713. TITLE IV–E PAYMENTS FOR EVIDENCE-BASED KINSHIP NAVIGATOR PROGRAMS.

Section 474(a) of the Social Security Act (42 U.S.C. 674(a)), as amended by section 50711(c), is amended—

(1) in paragraph (6), by striking the period at the end and inserting “; plus”; and

(2) by adding at the end the following:

“(7) an amount equal to 50 percent of the amounts expended by the State during the quarter as the Secretary determines are for kinship navi-
gator programs that meet the requirements described in section 427(a)(1) and that the Secretary determines are operated in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 471(e)(4)(C), without regard to whether the expenditures are incurred on behalf of children who are, or are potentially, eligible for foster care maintenance payments under this part.”.

PART II—ENHANCED SUPPORT UNDER TITLE IV—B

SEC. 50721. ELIMINATION OF TIME LIMIT FOR FAMILY REUNIFICATION SERVICES WHILE IN FOSTER CARE AND PERMITTING TIME-LIMITED FAMILY REUNIFICATION SERVICES WHEN A CHILD RETURNS HOME FROM FOSTER CARE.

(a) In general.—Section 431(a)(7) of the Social Security Act (42 U.S.C. 629a(a)(7)) is amended—

(1) in the paragraph heading, by striking “TIME-LIMITED FAMILY” and inserting “FAMILY”; and

(2) in subparagraph (A)—

(A) by striking “time-limited family” and inserting “family”;
(B) by inserting “or a child who has been returned home” after “child care institution”; and

(C) by striking “, but only during the 15-month period that begins on the date that the child, pursuant to section 475(5)(F), is considered to have entered foster care” and inserting “and to ensure the strength and stability of the reunification. In the case of a child who has been returned home, the services and activities shall only be provided during the 15-month period that begins on the date that the child returns home”.

(b) CONFORMING AMENDMENTS.—

(1) Section 430 of such Act (42 U.S.C. 629) is amended in the matter preceding paragraph (1), by striking “time-limited”.

(2) Subsections (a)(4), (a)(5)(A), and (b)(1) of section 432 of such Act (42 U.S.C. 629b) are amended by striking “time-limited” each place it appears.
SEC. 50722. REDUCING BUREAUCRACY AND UNNECESSARY DELAYS WHEN PLACING CHILDREN IN HOMES ACROSS STATE LINES.

(a) State Plan Requirement.—Section 471(a)(25) of the Social Security Act (42 U.S.C. 671(a)(25)) is amended—

(1) by striking “provide” and inserting “provides”; and

(2) by inserting “, which, in the case of a State other than the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, or American Samoa, not later than October 1, 2027, shall include the use of an electronic interstate case-processing system” before the first semicolon.

(b) Exemption of Indian Tribes.—Section 479B(c) of such Act (42 U.S.C. 679c(c)) is amended by adding at the end the following:

“(4) Inapplicability of state plan requirement to have in effect procedures providing for the use of an electronic interstate case-processing system.—The requirement in section 471(a)(25) that a State plan provide that the State shall have in effect procedures providing for the use of an electronic interstate case-processing system shall not apply to an Indian tribe,
tribal organization, or tribal consortium that elects
to operate a program under this part.”.

(c) FUNDING FOR THE DEVELOPMENT OF AN ELECTRONIC INTERSTATE CASE-PROCESSING SYSTEM TO EXPEDITE THE INTERSTATE PLACEMENT OF CHILDREN IN FOSTER CARE OR GUARDIANSHIP, OR FOR ADOPTION.—

Section 437 of such Act (42 U.S.C. 629g) is amended by adding at the end the following:

“(g) FUNDING FOR THE DEVELOPMENT OF AN ELECTRONIC INTERSTATE CASE-PROCESSING SYSTEM TO EXPEDITE THE INTERSTATE PLACEMENT OF CHILDREN IN FOSTER CARE OR GUARDIANSHIP, OR FOR ADOPTION.—

“(1) PURPOSE.—The purpose of this subsection is to facilitate the development of an electronic interstate case-processing system for the exchange of data and documents to expedite the placements of children in foster, guardianship, or adoptive homes across State lines.

“(2) REQUIREMENTS.—A State that seeks funding under this subsection shall submit to the Secretary the following:

“(A) A description of the goals and outcomes to be achieved, which goals and outcomes must result in—
“(i) reducing the time it takes for a child to be provided with a safe and appropriate permanent living arrangement across State lines;

“(ii) improving administrative processes and reducing costs in the foster care system; and

“(iii) the secure exchange of relevant case files and other necessary materials in real time, and timely communications and placement decisions regarding interstate placements of children.

“(B) A description of the activities to be funded in whole or in part with the funds, including the sequencing of the activities.

“(C) A description of the strategies for integrating programs and services for children who are placed across State lines.

“(D) Such other information as the Secretary may require.

“(3) FUNDING AUTHORITY.—The Secretary may provide funds to a State that complies with paragraph (2). In providing funds under this subsection, the Secretary shall prioritize States that are
not yet connected with the electronic interstate case-processing system referred to in paragraph (1).

“(4) USE OF FUNDS.—A State to which funding is provided under this subsection shall use the funding to support the State in connecting with, or enhancing or expediting services provided under, the electronic interstate case-processing system referred to in paragraph (1).

“(5) EVALUATIONS.—Not later than 1 year after the final year in which funds are awarded under this subsection, the Secretary shall submit to the Congress, and make available to the general public by posting on a website, a report that contains the following information:

“(A) How using the electronic interstate case-processing system developed pursuant to paragraph (4) has changed the time it takes for children to be placed across State lines.

“(B) The number of cases subject to the Interstate Compact on the Placement of Children that were processed through the electronic interstate case-processing system, and the number of interstate child placement cases that were processed outside the electronic interstate
case-processing system, by each State in each year.

“(C) The progress made by States in implementing the electronic interstate case-processing system.

“(D) How using the electronic interstate case-processing system has affected various metrics related to child safety and well-being, including the time it takes for children to be placed across State lines.

“(E) How using the electronic interstate case-processing system has affected administrative costs and caseworker time spent on placing children across State lines.

“(6) DATA INTEGRATION.—The Secretary, in consultation with the Secretariat for the Interstate Compact on the Placement of Children and the States, shall assess how the electronic interstate case-processing system developed pursuant to paragraph (4) could be used to better serve and protect children that come to the attention of the child welfare system, by—

“(A) connecting the system with other data systems (such as systems operated by State law enforcement and judicial agencies,
systems operated by the Federal Bureau of Investigation for the purposes of the Innocence Lost National Initiative, and other systems);

“(B) simplifying and improving reporting related to paragraphs (34) and (35) of section 471(a) regarding children or youth who have been identified as being a sex trafficking victim or children missing from foster care; and

“(C) improving the ability of States to quickly comply with background check requirements of section 471(a)(20), including checks of child abuse and neglect registries as required by section 471(a)(20)(B).”.

(d) RESERVATION OF FUNDS TO IMPROVE THE INTERSTATE PLACEMENT OF CHILDREN.—Section 437(b) of such Act (42 U.S.C. 629g(b)) is amended by adding at the end the following:

“(4) IMPROVING THE INTERSTATE PLACEMENT OF CHILDREN.—The Secretary shall reserve $5,000,000 of the amount made available for fiscal year 2018 for grants under subsection (g), and the amount so reserved shall remain available through fiscal year 2022.”.
SEC. 50723. ENHANCEMENTS TO GRANTS TO IMPROVE WELL-BEING OF FAMILIES AFFECTED BY SUBSTANCE ABUSE.

Section 437(f) of the Social Security Act (42 U.S.C. 629g(f)) is amended—

(1) in the subsection heading, by striking “INCREASE THE WELL-BEING OF, AND TO IMPROVE THE PERMANENCY OUTCOMES FOR, CHILDREN AFFECTED BY” and inserting “IMPLEMENT IV-E PREVENTION SERVICES, AND IMPROVE THE WELL-BEING OF, AND IMPROVE PERMANENCY OUTCOMES FOR, CHILDREN AND FAMILIES AFFECTED BY HERoin, OPIoIDS, AND OTHER”;

(2) by striking paragraph (2) and inserting the following:

“(2) REGIONAL PARTNERSHIP DEFINED.—In this subsection, the term ‘regional partnership’ means a collaborative agreement (which may be established on an interstate, State, or intrastate basis) entered into by the following:

“(A) MANDATORY PARTNERS FOR ALL PARTNERSHIP GRANTS.—

“(i) The State child welfare agency that is responsible for the administration of the State plan under this part and part E.
“(ii) The State agency responsible for administering the substance abuse prevention and treatment block grant provided under subpart II of part B of title XIX of the Public Health Service Act.

“(B) MANDATORY PARTNERS FOR PARTNERSHIP GRANTS PROPOSING TO SERVE CHILDREN IN OUT-OF-HOME PLACEMENTS.—If the partnership proposes to serve children in out-of-home placements, the Juvenile Court or Administrative Office of the Court that is most appropriate to oversee the administration of court programs in the region to address the population of families who come to the attention of the court due to child abuse or neglect.

“(C) OPTIONAL PARTNERS.—At the option of the partnership, any of the following:

“(i) An Indian tribe or tribal consortium.

“(ii) Nonprofit child welfare service providers.

“(iii) For-profit child welfare service providers.
“(iv) Community health service providers, including substance abuse treatment providers.

“(v) Community mental health providers.

“(vi) Local law enforcement agencies.

“(vii) School personnel.

“(viii) Tribal child welfare agencies (or a consortia of the agencies).

“(ix) Any other providers, agencies, personnel, officials, or entities that are related to the provision of child and family services under a State plan approved under this subpart.

“(D) EXCEPTION FOR REGIONAL PARTNERSHIPS WHERE THE LEAD APPLICANT IS AN INDIAN TRIBE OR TRIBAL CONSORTIA.—If an Indian tribe or tribal consortium enters into a regional partnership for purposes of this subsection, the Indian tribe or tribal consortium—

“(i) may (but is not required to) include the State child welfare agency as a partner in the collaborative agreement;

“(ii) may not enter into a collaborative agreement only with tribal child wel-
fare agencies (or a consortium of the agencies); and

“(iii) if the condition described in paragraph (2)(B) applies, may include tribal court organizations in lieu of other judicial partners.”;

(3) in paragraph (3)—

(A) in subparagraph (A)—

(i) by striking “2012 through 2016” and inserting “2017 through 2021”; and

(ii) by striking “$500,000 and not more than $1,000,000” and inserting “$250,000 and not more than $1,000,000”;

(B) in subparagraph (B)—

(i) in the subparagraph heading, by inserting “; PLANNING” after “APPROVAL”; (ii) in clause (i), by striking “clause (ii)” and inserting “clauses (ii) and (iii)”;

and

(iii) by adding at the end the following:

“(iii) SUFFICIENT PLANNING.—A grant awarded under this subsection shall be disbursed in two phases: a planning
phase (not to exceed 2 years) and an im-
plementation phase. The total disburse-
ment to a grantee for the planning phase
may not exceed $250,000, and may not ex-
ceed the total anticipated funding for the
implementation phase.”; and

(C) by adding at the end the following:

“(D) LIMITATION ON PAYMENT FOR A FIS-
CIAL YEAR.—No payment shall be made under
subparagraph (A) or (C) for a fiscal year until
the Secretary determines that the eligible part-
nership has made sufficient progress in meeting
the goals of the grant and that the members of
the eligible partnership are coordinating to a
reasonable degree with the other members of
the eligible partnership.”;

(4) in paragraph (4)—

(A) in subparagraph (B)—

(i) in clause (i), by inserting “, par-
ents, and families” after “children”;

(ii) in clause (ii), by striking “safety
and permanence for such children; and”
and inserting “safe, permanent caregiving
relationships for the children;”;

(4) in paragraph (4)—
(iii) in clause (iii), by striking “or” and inserting “increase reunification rates for children who have been placed in out-of-home care, or decrease”; and

(iv) by redesignating clause (iii) as clause (v) and inserting after clause (ii) the following:

“(iii) improve the substance abuse treatment outcomes for parents including retention in treatment and successful completion of treatment;

“(iv) facilitate the implementation, delivery, and effectiveness of prevention services and programs under section 471(e); and”;

(B) in subparagraph (D), by striking “where appropriate,”; and

(C) by striking subparagraphs (E) and (F) and inserting the following:

“(E) A description of a plan for sustaining the services provided by or activities funded under the grant after the conclusion of the grant period, including through the use of prevention services and programs under section 471(e) and other funds provided to the State
for child welfare and substance abuse prevention and treatment services.

“(F) Additional information needed by the Secretary to determine that the proposed activities and implementation will be consistent with research or evaluations showing which practices and approaches are most effective.”;

(5) in paragraph (5)(A), by striking “abuse treatment” and inserting “use disorder treatment including medication assisted treatment and in-home substance abuse disorder treatment and recovery”; 

(6) in paragraph (7)—

(A) by striking “and” at the end of subparagraph (C); and

(B) by redesignating subparagraph (D) as subparagraph (E) and inserting after subparagraph (C) the following:

“(D) demonstrate a track record of successful collaboration among child welfare, substance abuse disorder treatment and mental health agencies; and”;

(7) in paragraph (8)—

(A) in subparagraph (A)—
(i) by striking “establish indicators that will be” and inserting “review indicators that are”; and

(ii) by striking “in using funds made available under such grants to achieve the purpose of this subsection” and inserting “and establish a set of core indicators related to child safety, parental recovery, parenting capacity, and family well-being. In developing the core indicators, to the extent possible, indicators shall be made consistent with the outcome measures described in section 471(e)(6)”;

(B) in subparagraph (B)—

(i) in the matter preceding clause (i), by inserting “base the performance measures on lessons learned from prior rounds of regional partnership grants under this subsection, and” before “consult”; and

(ii) by striking clauses (iii) and (iv) and inserting the following:

“(iii) Other stakeholders or constituencies as determined by the Secretary.”;

(8) in paragraph (9)(A), by striking clause (i) and inserting the following:
"(i) Semiannual reports.—Not later than September 30 of each fiscal year in which a recipient of a grant under this subsection is paid funds under the grant, and every 6 months thereafter, the grant recipient shall submit to the Secretary a report on the services provided and activities carried out during the reporting period, progress made in achieving the goals of the program, the number of children, adults, and families receiving services, and such additional information as the Secretary determines is necessary. The report due not later than September 30 of the last such fiscal year shall include, at a minimum, data on each of the performance indicators included in the evaluation of the regional partnership.”; and

(9) in paragraph (10), by striking “2012 through 2016” and inserting “2017 through 2021”.

PART III—MISCELLANEOUS

SEC. 50731. REVIEWING AND IMPROVING LICENSING STANDARDS FOR PLACEMENT IN A RELATIVE FOSTER FAMILY HOME.

(a) IDENTIFICATION OF REPUTABLE MODEL LICENSING STANDARDS.—Not later than October 1, 2018, the Secretary of Health and Human Services shall identify reputable model licensing standards with respect to the licensing of foster family homes (as defined in section 472(c)(1) of the Social Security Act).

(b) STATE PLAN REQUIREMENT.—Section 471(a) of the Social Security Act (42 U.S.C. 671(a)) is amended—

(1) in paragraph (34)(B), by striking “and” after the semicolon;

(2) in paragraph (35)(B), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

“(36) provides that, not later than April 1, 2019, the State shall submit to the Secretary information addressing—

“(A) whether the State licensing standards are in accord with model standards identified by the Secretary, and if not, the reason for the specific deviation and a description as to why having a standard that is reasonably in accord
with the corresponding national model standards is not appropriate for the State;

“(B) whether the State has elected to waive standards established in 471(a)(10)(A) for relative foster family homes (pursuant to waiver authority provided by 471(a)(10)(D)), a description of which standards the State most commonly waives, and if the State has not elected to waive the standards, the reason for not waiving these standards;

“(C) if the State has elected to waive standards specified in subparagraph (B), how caseworkers are trained to use the waiver authority and whether the State has developed a process or provided tools to assist caseworkers in waiving nonsafety standards per the authority provided in 471(a)(10)(D) to quickly place children with relatives; and

“(D) a description of the steps the State is taking to improve caseworker training or the process, if any; and”.
SEC. 50732. DEVELOPMENT OF A STATEWIDE PLAN TO PREVENT CHILD ABUSE AND NEGLECT FATALITIES.

Section 422(b)(19) of the Social Security Act (42 U.S.C. 622(b)(19)) is amended to read as follows:

“(19) document steps taken to track and prevent child maltreatment deaths by including—

“(A) a description of the steps the State is taking to compile complete and accurate information on the deaths required by Federal law to be reported by the State agency referred to in paragraph (1), including gathering relevant information on the deaths from the relevant organizations in the State including entities such as State vital statistics department, child death review teams, law enforcement agencies, offices of medical examiners, or coroners; and

“(B) a description of the steps the State is taking to develop and implement a comprehensive, statewide plan to prevent the fatalities that involves and engages relevant public and private agency partners, including those in public health, law enforcement, and the courts.”.
SEC. 50733. MODERNIZING THE TITLE AND PURPOSE OF TITLE IV–E.

(a) PART HEADING.—The heading for part E of title IV of the Social Security Act (42 U.S.C. 670 et seq.) is amended to read as follows:

“PART E—FEDERAL PAYMENTS FOR FOSTER CARE, PREVENTION, AND PERMANENCY”.

(b) PURPOSE.—The first sentence of section 470 of such Act (42 U.S.C. 670) is amended—

(1) by striking “1995) and” and inserting “1995),”;

(2) by inserting “kinship guardianship assistance, and prevention services or programs specified in section 471(e)(1),” after “needs,”; and

(3) by striking “(commencing with the fiscal year which begins October 1, 1980)”.

SEC. 50734. EFFECTIVE DATES.

(a) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), subject to subsection (b), the amendments made by parts I through III of this subtitle shall take effect on October 1, 2018.

(2) EXCEPTIONS.—The amendments made by sections 50711(d), 50731, and 50733 shall take effect on the date of enactment of this Act.

(b) TRANSITION RULE.—
(1) In general.—In the case of a State plan under part B or E of title IV of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by parts I through III of this subtitle, the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature.

(2) Application to programs operated by Indian tribal organizations.—In the case of an Indian tribe, tribal organization, or tribal consortium which the Secretary of Health and Human Services determines requires time to take action necessary to comply with the additional requirements imposed by the amendments made by parts I through III of this
subtitle (whether the tribe, organization, or tribal consortium has a plan under section 479B of the Social Security Act or a cooperative agreement or contract entered into with a State), the Secretary shall provide the tribe, organization, or tribal consortium with such additional time as the Secretary determines is necessary for the tribe, organization, or tribal consortium to take the action to comply with the additional requirements before being regarded as failing to comply with the requirements.

PART IV—ENSURING THE NECESSITY OF A PLACEMENT THAT IS NOT IN A FOSTER FAMILY HOME

SEC. 50741. LIMITATION ON FEDERAL FINANCIAL PARTICIPATION FOR PLACEMENTS THAT ARE NOT IN FOSTER FAMILY HOMES.

(a) Limitation on Federal Financial Participation.—

(1) In general.—Section 472 of the Social Security Act (42 U.S.C. 672), as amended by section 50712(a), is amended—

(A) in subsection (a)(2)(C), by inserting “, but only to the extent permitted under subsection (k)” after “institution”; and

(B) by adding at the end the following:
“(k) **Limitation on Federal Financial Participation.**—

“(1) **In General.**—Beginning with the third week for which foster care maintenance payments are made under this section on behalf of a child placed in a child-care institution, no Federal payment shall be made to the State under section 474(a)(1) for amounts expended for foster care maintenance payments on behalf of the child unless—

“(A) the child is placed in a child-care institution that is a setting specified in paragraph (2) (or is placed in a licensed residential family-based treatment facility consistent with subsection (j)); and

“(B) in the case of a child placed in a qualified residential treatment program (as defined in paragraph (4)), the requirements specified in paragraph (3) and section 475A(c) are met.

“(2) **Specified Settings for Placement.**—

The settings for placement specified in this paragraph are the following:

“(A) A qualified residential treatment program (as defined in paragraph (4)).
“(B) A setting specializing in providing prenatal, post-partum, or parenting supports for youth.

“(C) In the case of a child who has attained 18 years of age, a supervised setting in which the child is living independently.

“(D) A setting providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims, in accordance with section 471(a)(9)(C).

“(3) ASSESSMENT TO DETERMINE APPROPRIATENESS OF PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.—

“(A) DEADLINE FOR ASSESSMENT.—In the case of a child who is placed in a qualified residential treatment program, if the assessment required under section 475A(c)(1) is not completed within 30 days after the placement is made, no Federal payment shall be made to the State under section 474(a)(1) for any amounts expended for foster care maintenance payments on behalf of the child during the placement.

“(B) DEADLINE FOR TRANSITION OUT OF PLACEMENT.—If the assessment required under
section 475A(c)(1) determines that the placement of a child in a qualified residential treatment program is not appropriate, a court disapproves such a placement under section 475A(c)(2), or a child who has been in an approved placement in a qualified residential treatment program is going to return home or be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home, Federal payments shall be made to the State under section 474(a)(1) for amounts expended for foster care maintenance payments on behalf of the child while the child remains in the qualified residential treatment program only during the period necessary for the child to transition home or to such a placement. In no event shall a State receive Federal payments under section 474(a)(1) for amounts expended for foster care maintenance payments on behalf of a child who remains placed in a qualified residential treatment program after the end of the 30-day period that begins on the date a determination is made that the placement is no longer the recommended or approved placement for the child.
“(4) QUALIFIED RESIDENTIAL TREATMENT PROGRAM.—For purposes of this part, the term ‘qualified residential treatment program’ means a program that—

“(A) has a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child by the assessment of the child required under section 475A(c);

“(B) subject to paragraphs (5) and (6), has registered or licensed nursing staff and other licensed clinical staff who—

“(i) provide care within the scope of their practice as defined by State law;

“(ii) are on-site according to the treatment model referred to in subparagraph (A); and

“(iii) are available 24 hours a day and 7 days a week;

“(C) to extent appropriate, and in accordance with the child’s best interests, facilitates
participation of family members in the child’s treatment program;

“(D) facilitates outreach to the family members of the child, including siblings, documents how the outreach is made (including contact information), and maintains contact information for any known biological family and fictive kin of the child;

“(E) documents how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained;

“(F) provides discharge planning and family-based aftercare support for at least 6 months post-discharge; and

“(G) is licensed in accordance with section 471(a)(10) and is accredited by any of the following independent, not-for-profit organizations:

“(i) The Commission on Accreditation of Rehabilitation Facilities (CARF).

“(ii) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

“(iii) The Council on Accreditation (COA).
“(iv) Any other independent, not-for-profit accrediting organization approved by the Secretary.

“(5) Administrative costs.—The prohibition in paragraph (1) on Federal payments under section 474(a)(1) shall not be construed as prohibiting Federal payments for administrative expenditures incurred on behalf of a child placed in a child-care institution and for which payment is available under section 474(a)(3).

“(6) Rule of construction.—The requirements in paragraph (4)(B) shall not be construed as requiring a qualified residential treatment program to acquire nursing and behavioral health staff solely through means of a direct employer to employee relationship.”.

(2) Conforming Amendment.—Section 474(a)(1) of the Social Security Act (42 U.S.C. 674(a)(1)), as amended by section 50712(b), is amended by striking “section 472(j)” and inserting “subsections (j) and (k) of section 472”.

(b) Definition of Foster Family Home, Child-Care Institution.—Section 472(e) of such Act (42 U.S.C. 672(c)(1)) is amended to read as follows:

“(c) Definitions.—For purposes of this part:
“(1) FOSTER FAMILY HOME.—

“(A) IN GENERAL.—The term ‘foster family home’ means the home of an individual or family—

“(i) that is licensed or approved by the State in which it is situated as a foster family home that meets the standards established for the licensing or approval; and

“(ii) in which a child in foster care has been placed in the care of an individual, who resides with the child and who has been licensed or approved by the State to be a foster parent—

“(I) that the State deems capable of adhering to the reasonable and prudent parent standard;

“(II) that provides 24-hour substitute care for children placed away from their parents or other caretakers; and

“(III) that provides the care for not more than six children in foster care.

“(B) STATE FLEXIBILITY.—The number of foster children that may be cared for in a home
under subparagraph (A) may exceed the numerical limitation in subparagraph (A)(ii)(III), at the option of the State, for any of the following reasons:

“(i) To allow a parenting youth in foster care to remain with the child of the parenting youth.

“(ii) To allow siblings to remain together.

“(iii) To allow a child with an established meaningful relationship with the family to remain with the family.

“(iv) To allow a family with special training or skills to provide care to a child who has a severe disability.

“(C) Rule of Construction.—Subparagraph (A) shall not be construed as prohibiting a foster parent from renting the home in which the parent cares for a foster child placed in the parent’s care.

“(2) Child-care institution.—

“(A) In general.—The term ‘child-care institution’ means a private child-care institution, or a public child-care institution which accommodates no more than 25 children, which is
licensed by the State in which it is situated or has been approved by the agency of the State responsible for licensing or approval of institutions of this type as meeting the standards established for the licensing.

“(B) SUPERVISED SETTINGS.—In the case of a child who has attained 18 years of age, the term shall include a supervised setting in which the individual is living independently, in accordance with such conditions as the Secretary shall establish in regulations.

“(C) EXCLUSIONS.—The term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.”.

(c) TRAINING FOR STATE JUDGES, ATTORNEYS, AND OTHER LEGAL PERSONNEL IN CHILD WELFARE CASES.—Section 438(b)(1) of such Act (42 U.S.C. 629h(b)(1)) is amended in the matter preceding subparagraph (A) by inserting “shall provide for the training of judges, attorneys, and other legal personnel in child welfare cases on Federal child welfare policies and payment limitations with respect to children in foster care who are
placed in settings that are not a foster family home,” after
“with respect to the child,”.

(d) Assurance of Nonimpact on Juvenile Justice System.—

(1) State Plan Requirement.—Section 471(a) of such Act (42 U.S.C. 671(a)), as amended by section 50731, is further amended by adding at the end the following:

“(37) includes a certification that, in response to the limitation imposed under section 472(k) with respect to foster care maintenance payments made on behalf of any child who is placed in a setting that is not a foster family home, the State will not enact or advance policies or practices that would result in a significant increase in the population of youth in the State’s juvenile justice system.”.

(2) GAO Study and Report.—The Comptroller General of the United States shall evaluate the impact, if any, on State juvenile justice systems of the limitation imposed under section 472(k) of the Social Security Act (as added by section 50741(a)(1)) on foster care maintenance payments made on behalf of any child who is placed in a setting that is not a foster family home, in accordance with the amendments made by subsections (a) and
(b) of this section. In particular, the Comptroller General shall evaluate the extent to which children in foster care who also are subject to the juvenile justice system of the State are placed in a facility under the jurisdiction of the juvenile justice system and whether the lack of available congregate care placements under the jurisdiction of the child welfare systems is a contributing factor to that result. Not later than December 31, 2025, the Comptroller General shall submit to Congress a report on the results of the evaluation.

SEC. 50742. ASSESSMENT AND DOCUMENTATION OF THE NEED FOR PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.

Section 475A of the Social Security Act (42 U.S.C. 675a) is amended by adding at the end the following:

“(c) ASSESSMENT, DOCUMENTATION, AND JUDICIAL DETERMINATION REQUIREMENTS FOR PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.—In the case of any child who is placed in a qualified residential treatment program (as defined in section 472(k)(4)), the following requirements shall apply for purposes of approving the case plan for the child and the case system review procedure for the child:
“(1)(A) Within 30 days of the start of each placement in such a setting, a qualified individual (as defined in subparagraph (D)) shall—

“(i) assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool approved by the Secretary;

“(ii) determine whether the needs of the child can be met with family members or through placement in a foster family home or, if not, which setting from among the settings specified in section 472(k)(2) would provide the most effective and appropriate level of care for the child in the least restrictive environment and be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and

“(iii) develop a list of child-specific short- and long-term mental and behavioral health goals.

“(B)(i) The State shall assemble a family and permanency team for the child in accordance with the requirements of clauses (ii) and (iii). The qualified individual conducting the assessment required under subparagraph (A) shall work in conjunction
with the family of, and permanency team for, the child while conducting and making the assessment.

“(ii) The family and permanency team shall consist of all appropriate biological family members, relative, and fictive kin of the child, as well as, as appropriate, professionals who are a resource to the family of the child, such as teachers, medical or mental health providers who have treated the child, or clergy. In the case of a child who has attained age 14, the family and permanency team shall include the members of the permanency planning team for the child that are selected by the child in accordance with section 475(5)(C)(iv).

“(iii) The State shall document in the child’s case plan—

“(I) the reasonable and good faith effort of the State to identify and include all the individuals described in clause (ii) on the child’s family and permanency team;

“(II) all contact information for members of the family and permanency team, as well as contact information for other family members and fictive kin who are not part of the family and permanency team;
“(III) evidence that meetings of the family and permanency team, including meetings relating to the assessment required under subparagraph (A), are held at a time and place convenient for family;

“(IV) if reunification is the goal, evidence demonstrating that the parent from whom the child was removed provided input on the members of the family and permanency team;

“(V) evidence that the assessment required under subparagraph (A) is determined in conjunction with the family and permanency team;

“(VI) the placement preferences of the family and permanency team relative to the assessment that recognizes children should be placed with their siblings unless there is a finding by the court that such placement is contrary to their best interest; and

“(VII) if the placement preferences of the family and permanency team and child are not the placement setting recommended by the qualified individual conducting the assessment under subparagraph (A), the reasons why the preferences of the team and of the child were not recommended.
“(C) In the case of a child who the qualified individual conducting the assessment under subparagraph (A) determines should not be placed in a foster family home, the qualified individual shall specify in writing the reasons why the needs of the child cannot be met by the family of the child or in a foster family home. A shortage or lack of foster family homes shall not be an acceptable reason for determining that the needs of the child cannot be met in a foster family home. The qualified individual also shall specify in writing why the recommended placement in a qualified residential treatment program is the setting that will provide the child with the most effective and appropriate level of care in the least restrictive environment and how that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child.

“(D)(i) Subject to clause (ii), in this subsection, the term ‘qualified individual’ means a trained professional or licensed clinician who is not an employee of the State agency and who is not connected to, or affiliated with, any placement setting in which children are placed by the State.
“(ii) The Secretary may approve a request of a State to waive any requirement in clause (i) upon a submission by the State, in accordance with criteria established by the Secretary, that certifies that the trained professionals or licensed clinicians with responsibility for performing the assessments described in subparagraph (A) shall maintain objectivity with respect to determining the most effective and appropriate placement for a child.

“(2) Within 60 days of the start of each placement in a qualified residential treatment program, a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or an administrative body appointed or approved by the court, independently, shall—

“(A) consider the assessment, determination, and documentation made by the qualified individual conducting the assessment under paragraph (1);

“(B) determine whether the needs of the child can be met through placement in a foster family home or, if not, whether placement of the child in a qualified residential treatment program provides the most effective and appropriate level of care for the child in the least re-
restrictive environment and whether that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and

“(C) approve or disapprove the placement.

“(3) The written documentation made under paragraph (1)(C) and documentation of the determination and approval or disapproval of the placement in a qualified residential treatment program by a court or administrative body under paragraph (2) shall be included in and made part of the case plan for the child.

“(4) As long as a child remains placed in a qualified residential treatment program, the State agency shall submit evidence at each status review and each permanency hearing held with respect to the child—

“(A) demonstrating that ongoing assessment of the strengths and needs of the child continues to support the determination that the needs of the child cannot be met through placement in a foster family home, that the placement in a qualified residential treatment program provides the most effective and appropriate level of care for the child in the least re-
strictive environment, and that the placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child;

“(B) documenting the specific treatment or service needs that will be met for the child in the placement and the length of time the child is expected to need the treatment or services; and

“(C) documenting the efforts made by the State agency to prepare the child to return home or to be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home.

“(5) In the case of any child who is placed in a qualified residential treatment program for more than 12 consecutive months or 18 nonconsecutive months (or, in the case of a child who has not attained age 13, for more than 6 consecutive or non-consecutive months), the State agency shall submit to the Secretary—

“(A) the most recent versions of the evidence and documentation specified in paragraph (4); and
“(B) the signed approval of the head of
the State agency for the continued placement of
the child in that setting.”.

SEC. 50743. PROTOCOLS TO PREVENT INAPPROPRIATE DI-
AGNOSES.

(a) STATE PLAN REQUIREMENT.—Section
422(b)(15)(A) of the Social Security Act (42 U.S.C.
622(b)(15)(A)) is amended—

(1) in clause (vi), by striking “and” after the
semicolon;

(2) by redesignating clause (vii) as clause (viii);
and

(3) by inserting after clause (vi) the following:

“(vii) the procedures and protocols
the State has established to ensure that
children in foster care placements are not
inappropriately diagnosed with mental ill-
ness, other emotional or behavioral dis-
orders, medically fragile conditions, or de-
velopmental disabilities, and placed in set-
tings that are not foster family homes as
a result of the inappropriate diagnoses;
and”.
(b) Evaluation.—Section 476 of such Act (42 U.S.C. 676), as amended by section 50711(d), is further amended by adding at the end the following:

‘‘(e) Evaluation of State Procedures and Protocols to Prevent Inappropriate Diagnoses of Mental Illness or Other Conditions.—The Secretary shall conduct an evaluation of the procedures and protocols established by States in accordance with the requirements of section 422(b)(15)(A)(vii). The evaluation shall analyze the extent to which States comply with and enforce the procedures and protocols and the effectiveness of various State procedures and protocols and shall identify best practices. Not later than January 1, 2020, the Secretary shall submit a report on the results of the evaluation to Congress.’’.

SEC. 50744. ADDITIONAL DATA AND REPORTS REGARDING CHILDREN PLACED IN A SETTING THAT IS NOT A FOSTER FAMILY HOME.

Section 479A(a)(7)(A) of the Social Security Act (42 U.S.C. 679b(a)(7)(A)) is amended by striking clauses (i) through (vi) and inserting the following:

‘‘(i) with respect to each such placement—

‘‘(I) the type of the placement setting, including whether the place-
ment is shelter care, a group home
and if so, the range of the child popu-
lation in the home, a residential treat-
ment facility, a hospital or institution
providing medical, rehabilitative, or
psychiatric care, a setting specializing
in providing prenatal, post-partum, or
parenting supports, or some other
kind of child-care institution and if so,
what kind;

“(II) the number of children in
the placement setting and the age,
race, ethnicity, and gender of each of
the children;

“(III) for each child in the place-
ment setting, the length of the place-
ment of the child in the setting,
whether the placement of the child in
the setting is the first placement of
the child and if not, the number and
type of previous placements of the
child, and whether the child has spe-
cial needs or another diagnosed men-
tal or physical illness or condition; and
“(IV) the extent of any specialized education, treatment, counseling, or other services provided in the setting; and

“(ii) separately, the number and ages of children in the placements who have a permanency plan of another planned permanent living arrangement; and”.

SEC. 50745. CRIMINAL RECORDS CHECKS AND CHECKS OF CHILD ABUSE AND NEGLECT REGISTRIES FOR ADULTS WORKING IN CHILD-CARE INSTITUTIONS AND OTHER GROUP CARE SETTINGS.

(a) State Plan Requirement.—Section 471(a)(20) of the Social Security Act (42 U.S.C. 671(a)(20)) is amended—

(1) in subparagraph (A)(ii), by striking “and” after the semicolon;

(2) in subparagraph (B)(iii), by striking “and” after the semicolon;

(3) in subparagraph (C), by adding “and” after the semicolon; and

(4) by inserting after subparagraph (C), the following new subparagraph:
“(D) provides procedures for any child-care institution, including a group home, residential treatment center, shelter, or other congregate care setting, to conduct criminal records checks, including fingerprint-based checks of national crime information databases (as defined in section 534(f)(3)(A) of title 28, United States Code), and checks described in subparagraph (B) of this paragraph, on any adult working in a child-care institution, including a group home, residential treatment center, shelter, or other congregate care setting, unless the State reports to the Secretary the alternative criminal records checks and child abuse registry checks the State conducts on any adult working in a child-care institution, including a group home, residential treatment center, shelter, or other congregate care setting, and why the checks specified in this subparagraph are not appropriate for the State;”.

(b) TECHNICAL AMENDMENTS.—Subparagraphs (A) and (C) of section 471(a)(20) of the Social Security Act (42 U.S.C. 671(a)(20)) are each amended by striking “section 534(e)(3)(A)” and inserting “section 534(f)(3)(A)”.

SEC. 50746. EFFECTIVE DATES; APPLICATION TO WAIVERS.

(a) Effective Dates.—

(1) In general.—Subject to paragraph (2) and subsections (b), (c), and (d), the amendments made by this part shall take effect as if enacted on January 1, 2018.

(2) Transition rule.—In the case of a State plan under part B or E of title IV of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this part, the State plan shall not be regarded as failing to comply with the requirements of part B or E of title IV of such Act solely on the basis of the failure of the plan to meet the additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature.
(b) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION FOR PLACEMENTS THAT ARE NOT IN FOSTER FAMILY HOMES AND RELATED PROVISIONS.—

(1) IN GENERAL.—The amendments made by sections 50741(a), 50741(b), 50741(d), and 50742 shall take effect on October 1, 2019.

(2) STATE OPTION TO DELAY EFFECTIVE DATE FOR NOT MORE THAN 2 YEARS.—If a State requests a delay in the effective date, the Secretary of Health and Human Services shall delay the effective date provided for in paragraph (1) with respect to the State for the amount of time requested by the State, not to exceed 2 years. If the effective date is so delayed for a period with respect to a State under the preceding sentence, then—

(A) notwithstanding section 50734, the date that the amendments made by section 50711(c) take effect with respect to the State shall be delayed for the period; and

(B) in applying section 474(a)(6) of the Social Security Act with respect to the State, “on or after the date this paragraph takes effect with respect to the State” is deemed to be substituted for “after September 30, 2019” in subparagraph (A)(i)(I) of such section.
(c) Criminal Records Checks and Checks of Child Abuse and Neglect Registries for Adults Working in Child-care Institutions and Other Group Care Settings.—Subject to subsection (a)(2), the amendments made by section 50745 shall take effect on October 1, 2018.

(d) Application to States With Waivers.—In the case of a State that, on the date of enactment of this Act, has in effect a waiver approved under section 1130 of the Social Security Act (42 U.S.C. 1320a–9), the amendments made by this part shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent the amendments are inconsistent with the terms of the waiver.

PART V—CONTINUING SUPPORT FOR CHILD AND FAMILY SERVICES

SEC. 50751. SUPPORTING AND RETAINING FOSTER FAMILIES FOR CHILDREN.

(a) Supporting and Retaining Foster Parents as a Family Support Service.—Section 431(a)(2)(B) of the Social Security Act (42 U.S.C. 631(a)(2)(B)) is amended by redesignating clauses (iii) through (vi) as clauses (iv) through (vii), respectively, and inserting after clause (ii) the following:
“(iii) To support and retain foster families so they can provide quality family-based settings for children in foster care.”.

(b) SUPPORT FOR FOSTER FAMILY HOMES.—Section 436 of such Act (42 U.S.C. 629f) is amended by adding at the end the following:

“(c) SUPPORT FOR FOSTER FAMILY HOMES.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2018, $8,000,000 for the Secretary to make competitive grants to States, Indian tribes, or tribal consortia to support the recruitment and retention of high-quality foster families to increase their capacity to place more children in family settings, focused on States, Indian tribes, or tribal consortia with the highest percentage of children in non-family settings. The amount appropriated under this subparagraph shall remain available through fiscal year 2022.”.

SEC. 50752. EXTENSION OF CHILD AND FAMILY SERVICES PROGRAMS.

(a) Extension of Stephanie Tubbs Jones Child Welfare Services Program.—Section 425 of the Social Security Act (42 U.S.C. 625) is amended by striking “2012 through 2016” and inserting “2017 through 2021”.
(b) Extension of Promoting Safe and Stable Families Program Authorizations.—

(1) In general.—Section 436(a) of such Act (42 U.S.C. 629f(a)) is amended by striking all that follows “$345,000,000” and inserting “for each of fiscal years 2017 through 2021.”.

(2) Discretionary Grants.—Section 437(a) of such Act (42 U.S.C. 629g(a)) is amended by striking “2012 through 2016” and inserting “2017 through 2021”.

c) Extension of Funding Reservations for Monthly Caseworker Visits and Regional Partnership Grants.—Section 436(b) of such Act (42 U.S.C. 629f(b)) is amended—

(1) in paragraph (4)(A), by striking “2012 through 2016” and inserting “2017 through 2021”; and

(2) in paragraph (5), by striking “2012 through 2016” and inserting “2017 through 2021”.

d) Reauthorization of Funding for State Courts.—

(1) Extension of Program.—Section 438(e)(1) of such Act (42 U.S.C. 629h(e)(1)) is amended by striking “2012 through 2016” and inserting “2017 through 2021”.

(2) Extension of Federal Share.—Section 438(d) of such Act (42 U.S.C. 629h(d)) is amended by striking “2012 through 2016” and inserting “2017 through 2021”.

(e) Repeal of Expired Provisions.—Section 438(e) of such Act (42 U.S.C. 629h(e)) is repealed.

SEC. 50753. IMPROVEMENTS TO THE JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM AND RELATED PROVISIONS.

(a) Authority To Serve Former Foster Youth Up To Age 23.—Section 477 of the Social Security Act (42 U.S.C. 677) is amended—

(1) in subsection (a)(5), by inserting “(or 23 years of age, in the case of a State with a certification under subsection (b)(3)(A)(ii) to provide assistance and services to youths who have aged out of foster care and have not attained such age, in accordace with such subsection)” after “21 years of age”;

(2) in subsection (b)(3)(A)—

(A) by inserting “(i)” before “A certification”;  

(B) by striking “children who have left foster care” and all that follows through the period and inserting “youths who have aged out
of foster care and have not attained 21 years of age.”; and

(C) by adding at the end the following:

“(ii) If the State has elected under section 475(8)(B) to extend eligibility for foster care to all children who have not attained 21 years of age, or if the Secretary determines that the State agency responsible for administering the State plans under this part and part B uses State funds or any other funds not provided under this part to provide services and assistance for youths who have aged out of foster care that are comparable to the services and assistance the youths would receive if the State had made such an election, the certification required under clause (i) may provide that the State will provide assistance and services to youths who have aged out of foster care and have not attained 23 years of age.”; and

(3) in subsection (b)(3)(B), by striking “children who have left foster care” and all that follows through the period and inserting “youths who have aged out of foster care and have not attained 21 years of age (or 23 years of age, in the case of a State with a certification under subparagraph (A)(i)
to provide assistance and services to youths who have aged out of foster care and have not attained such age, in accordance with subparagraph (A)(ii)).”.

(b) Authority To Redistribute Unspent Funds.—Section 477(d) of such Act (42 U.S.C. 677(d)) is amended—

(1) in paragraph (4), by inserting “or does not expend allocated funds within the time period specified under section 477(d)(3)” after “provided by the Secretary”; and

(2) by adding at the end the following:

“(5) Redistribution of unexpended amounts.—

“(A) Availability of amounts.—To the extent that amounts paid to States under this section in a fiscal year remain unexpended by the States at the end of the succeeding fiscal year, the Secretary may make the amounts available for redistribution in the second succeeding fiscal year among the States that apply for additional funds under this section for that second succeeding fiscal year.

“(B) Redistribution.—
“(i) In general.—The Secretary shall redistribute the amounts made available under subparagraph (A) for a fiscal year among eligible applicant States. In this subparagraph, the term ‘eligible applicant State’ means a State that has applied for additional funds for the fiscal year under subparagraph (A) if the Secretary determines that the State will use the funds for the purpose for which originally allotted under this section.

“(ii) Amount to be redistributed.—The amount to be redistributed to each eligible applicant State shall be the amount so made available multiplied by the State foster care ratio, (as defined in subsection (c)(4), except that, in such subsection, ‘all eligible applicant States (as defined in subsection (d)(5)(B)(i))’ shall be substituted for ‘all States’).

“(iii) Treatment of redistributed amount.—Any amount made available to a State under this paragraph shall be regarded as part of the allotment of the
State under this section for the fiscal year in which the redistribution is made.

“(C) Tribes.—For purposes of this paragraph, the term ‘State’ includes an Indian tribe, tribal organization, or tribal consortium that receives an allotment under this section.”.

(e) Expanding and Clarifying the Use of Education and Training Vouchers.—

(1) In General.—Section 477(i)(3) of such Act (42 U.S.C. 677(i)(3)) is amended—

(A) by striking “on the date” and all that follows through “23” and inserting “to remain eligible until they attain 26”; and

(B) by inserting “, but in no event may a youth participate in the program for more than 5 years (whether or not consecutive)” before the period.

(2) Conforming Amendment.—Section 477(i)(1) of such Act (42 U.S.C. 677(i)(1)) is amended by inserting “who have attained 14 years of age” before the period.

(d) Other Improvements.—Section 477 of such Act (42 U.S.C. 677), as amended by subsections (a), (b), and (c), is amended—
(1) in the section heading, by striking “INDE-PENDENCE PROGRAM” and inserting “PROGRAM FOR SUCCESSFUL TRANSITION TO ADULT-HOOD”;

(2) in subsection (a)—

(A) in paragraph (1)—

(i) by striking “identify children who are likely to remain in foster care until 18 years of age and to help these children make the transition to self-sufficiency by providing services” and inserting “support all youth who have experienced foster care at age 14 or older in their transition to adulthood through transitional services”;

(ii) by inserting “and post-secondary education” after “high school diploma”; and

(iii) by striking “training in daily living skills, training in budgeting and financial management skills” and inserting “training and opportunities to practice daily living skills (such as financial literacy training and driving instruction)”;

(B) in paragraph (2), by striking “who are likely to remain in foster care until 18 years of
age receive the education, training, and services necessary to obtain employment” and inserting “who have experienced foster care at age 14 or older achieve meaningful, permanent connections with a caring adult”; (C) in paragraph (3), by striking “who are likely to remain in foster care until 18 years of age prepare for and enter postsecondary training and education institutions” and inserting “who have experienced foster care at age 14 or older engage in age or developmentally appropriate activities, positive youth development, and experiential learning that reflects what their peers in intact families experience”; and (D) by striking paragraph (4) and redesignating paragraphs (5) through (8) as paragraphs (4) through (7); (3) in subsection (b)— (A) in paragraph (2)(D), by striking “adolescents” and inserting “youth”; and (B) in paragraph (3)— (i) in subparagraph (D)— (I) by inserting “including training on youth development” after “to provide training”; and
(II) by striking “adolescents preparing for independent living” and all that follows through the period and inserting “youth preparing for a successful transition to adulthood and making a permanent connection with a caring adult.”;

(ii) in subparagraph (H), by striking “adolescents” each place it appears and inserting “youth”; and

(iii) in subparagraph (K)—

(I) by striking “an adolescent” and inserting “a youth”; and

(II) by striking “the adolescent” each place it appears and inserting “the youth”; and

(4) in subsection (f), by striking paragraph (2) and inserting the following:

“(2) REPORT TO CONGRESS.—Not later than October 1, 2019, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the National Youth in Transition Database and any other databases in which States report outcome measures relating to children
in foster care and children who have aged out of foster care or left foster care for kinship guardianship or adoption. The report shall include the following:

“(A) A description of the reasons for entry into foster care and of the foster care experiences, such as length of stay, number of placement settings, case goal, and discharge reason of 17-year-olds who are surveyed by the National Youth in Transition Database and an analysis of the comparison of that description with the reasons for entry and foster care experiences of children of other ages who exit from foster care before attaining age 17.

“(B) A description of the characteristics of the individuals who report poor outcomes at ages 19 and 21 to the National Youth in Transition Database.

“(C) Benchmarks for determining what constitutes a poor outcome for youth who remain in or have exited from foster care and plans the executive branch will take to incorporate these benchmarks in efforts to evaluate child welfare agency performance in providing services to children transitioning from foster care.
“(D) An analysis of the association between types of placement, number of overall placements, time spent in foster care, and other factors, and outcomes at ages 19 and 21.

“(E) An analysis of the differences in outcomes for children in and formerly in foster care at age 19 and 21 among States.”.

(e) Clarifying Documentation Provided to Foster Youth Leaving Foster Care.—Section 475(5)(I) of such Act (42 U.S.C. 675(5)(I)) is amended by inserting after “REAL ID Act of 2005” the following:

“, and any official documentation necessary to prove that the child was previously in foster care”.

PART VI—CONTINUING INCENTIVES TO STATES TO PROMOTE ADOPTION AND LEGAL GUARDIANSHIP

SEC. 50761. REAUTHORIZING ADOPTION AND LEGAL GUARDIANSHIP INCENTIVE PROGRAMS.

(a) In General.—Section 473A of the Social Security Act (42 U.S.C. 673b) is amended—

(1) in subsection (b)(4), by striking “2013 through 2015” and inserting “2016 through 2020”;

(2) in subsection (h)(1)(D), by striking “2016” and inserting “2021”; and
(3) in subsection (h)(2), by striking “2016” and inserting “2021”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if enacted on October 1, 2017.

PART VII—TECHNICAL CORRECTIONS

SEC. 50771. TECHNICAL CORRECTIONS TO DATA EXCHANGE STANDARDS TO IMPROVE PROGRAM COORDINATION.

(a) IN GENERAL.—Section 440 of the Social Security Act (42 U.S.C. 629m) is amended to read as follows:

“SEC. 440. DATA EXCHANGE STANDARDS FOR IMPROVED INTEROPERABILITY.

“(a) DESIGNATION.—The Secretary shall, in consultation with an interagency work group established by the Office of Management and Budget and considering State government perspectives, by rule, designate data exchange standards to govern, under this part and part E—

“(1) necessary categories of information that State agencies operating programs under State plans approved under this part are required under applicable Federal law to electronically exchange with another State agency; and

“(2) Federal reporting and data exchange required under applicable Federal law.
“(b) REQUIREMENTS.—The data exchange standards required by paragraph (1) shall, to the extent practicable—

“(1) incorporate a widely accepted, non-proprietary, searchable, computer-readable format, such as the Extensible Markup Language;

“(2) contain interoperable standards developed and maintained by intergovernmental partnerships, such as the National Information Exchange Model;

“(3) incorporate interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance;

“(4) be consistent with and implement applicable accounting principles;

“(5) be implemented in a manner that is cost-effective and improves program efficiency and effectiveness; and

“(6) be capable of being continually upgraded as necessary.

“(c) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a change to existing data exchange standards found to be effective and efficient.”.

(b) EFFECTIVE DATE.—Not later than the date that is 24 months after the date of the enactment of this sec-
tion, the Secretary of Health and Human Services shall
issue a proposed rule that—

(1) identifies federally required data exchanges,
include specification and timing of exchanges to be
standardized, and address the factors used in deter-
mining whether and when to standardize data ex-
changes; and

(2) specifies State implementation options and
describes future milestones.

SEC. 50772. TECHNICAL CORRECTIONS TO STATE REQUIRE-
MENT TO ADDRESS THE DEVELOPMENTAL
NEEDS OF YOUNG CHILDREN.

Section 422(b)(18) of the Social Security Act (42
U.S.C. 622(b)(18)) is amended by striking “such chil-
dren” and inserting “all vulnerable children under 5 years
of age”.

PART VIII—ENSURING STATES REINVEST SAV-
INGS RESULTING FROM INCREASE IN ADOP-
TION ASSISTANCE

SEC. 50781. DELAY OF ADOPTION ASSISTANCE PHASE-IN.

(a) In General.—The table in section 473(e)(1)(B)
of the Social Security Act (42 U.S.C. 673(e)(1)(B)) is
amended by striking the last 2 rows and inserting the fol-
lowing:

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2017 through 2023 ............................ 2
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(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if enacted on January 1, 2018.

SEC. 50782. GAO STUDY AND REPORT ON STATE REINVESTMENT OF SAVINGS RESULTING FROM INCREASE IN ADOPTION ASSISTANCE.

(a) STUDY.—The Comptroller General of the United States shall study the extent to which States are complying with the requirements of section 473(a)(8) of the Social Security Act (42 U.S.C. 673(a)(8)) relating to the effects of phasing out the AFDC income eligibility requirements for adoption assistance payments under section 473 of the Social Security Act, as enacted by section 402 of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110–351; 122 Stat. 3975) and amended by section 206 of the Preventing Sex Trafficking and Strengthening Families Act (Public Law 113–183; 128 Stat. 1919). In particular, the Comptroller General shall analyze the extent to which States are complying with the following requirements under section 473(a)(8)(D) of the Social Security Act:
(1) The requirement to spend an amount equal to the amount of the savings (if any) in State expenditures under part E of title IV of the Social Security Act resulting from phasing out the AFDC income eligibility requirements for adoption assistance payments under section 473 of such Act to provide to children of families any service that may be provided under part B or E of title IV of such Act.

(2) The requirement that a State shall spend not less than 30 percent of the amount of any savings described in paragraph (1) on post-adoption services, post-guardianship services, and services to support and sustain positive permanent outcomes for children who otherwise might enter into foster care under the responsibility of the State, with at least $\frac{2}{3}$ of the spending by the State to comply with the 30 percent requirement being spent on post-adoption and post-guardianship services.

(b) REPORT.—The Comptroller General of the United States shall submit to the Committee on Finance of the Senate, the Committee on Ways and Means of the House of Representatives, and the Secretary of Health and Human Services a report that contains the results of the study required by subsection (a), including rec-
ommendations to ensure compliance with laws referred to in subsection (a).

TITLE VIII—SUPPORTING SOCIAL IMPACT PARTNERSHIPS TO PAY FOR RESULTS

SEC. 50801. SHORT TITLE.
This subtitle may be cited as the “Social Impact Partnerships to Pay for Results Act”.

SEC. 50802. SOCIAL IMPACT PARTNERSHIPS TO PAY FOR RESULTS.

Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(1) in the title heading, by striking “TO STATES” and inserting “AND PROGRAMS”; and

(2) by adding at the end the following:

“Subtitle C—Social Impact Demonstration Projects

“PURPOSES

“Sec. 2051. The purposes of this subtitle are the fol-

“(1) To improve the lives of families and indi-

viduals in need in the United States by funding so-

cial programs that achieve real results.

“(2) To redirect funds away from programs

that, based on objective data, are ineffective, and
into programs that achieve demonstrable, measurable results.

“(3) To ensure Federal funds are used effectively on social services to produce positive outcomes for both service recipients and taxpayers.

“(4) To establish the use of social impact partnerships to address some of our Nation’s most pressing problems.

“(5) To facilitate the creation of public-private partnerships that bundle philanthropic or other private resources with existing public spending to scale up effective social interventions already being implemented by private organizations, nonprofits, charitable organizations, and State and local governments across the country.

“(6) To bring pay-for-performance to the social sector, allowing the United States to improve the impact and effectiveness of vital social services programs while redirecting inefficient or duplicative spending.

“(7) To incorporate outcomes measurement and randomized controlled trials or other rigorous methodologies for assessing program impact.

“SOCIAL IMPACT PARTNERSHIP APPLICATION

“Sec. 2052. (a) NOTICE.—Not later than 1 year after the date of the enactment of this subtitle, the Sec-
Secretary of the Treasury, in consultation with the Federal Interagency Council on Social Impact Partnerships, shall publish in the Federal Register a request for proposals from States or local governments for social impact partnership projects in accordance with this section.

“(b) REQUIRED OUTCOMES FOR SOCIAL IMPACT PARTNERSHIP PROJECT.—To qualify as a social impact partnership project under this subtitle, a project must produce one or more measurable, clearly defined outcomes that result in social benefit and Federal, State, or local savings through any of the following:

“(1) Increasing work and earnings by individuals in the United States who are unemployed for more than 6 consecutive months.

“(2) Increasing employment and earnings of individuals who have attained 16 years of age but not 25 years of age.

“(3) Increasing employment among individuals receiving Federal disability benefits.

“(4) Reducing the dependence of low-income families on Federal means-tested benefits.

“(5) Improving rates of high school graduation.

“(6) Reducing teen and unplanned pregnancies.
“(7) Improving birth outcomes and early childhood health and development among low-income families and individuals.

“(8) Reducing rates of asthma, diabetes, or other preventable diseases among low-income families and individuals to reduce the utilization of emergency and other high-cost care.

“(9) Increasing the proportion of children living in two-parent families.

“(10) Reducing incidences and adverse consequences of child abuse and neglect.

“(11) Reducing the number of youth in foster care by increasing adoptions, permanent guardianship arrangements, reunifications, or placements with a fit and willing relative, or by avoiding placing children in foster care by ensuring they can be cared for safely in their own homes.

“(12) Reducing the number of children and youth in foster care residing in group homes, child care institutions, agency-operated foster homes, or other non-family foster homes, unless it is determined that it is in the interest of the child’s long-term health, safety, or psychological well-being to not be placed in a family foster home.
“(13) Reducing the number of children returning to foster care.

“(14) Reducing recidivism among juvenile offenders, individuals released from prison, or other high-risk populations.

“(15) Reducing the rate of homelessness among our most vulnerable populations.

“(16) Improving the health and well-being of those with mental, emotional, and behavioral health needs.

“(17) Improving the educational outcomes of special-needs or low-income children.

“(18) Improving the employment and well-being of returning United States military members.

“(19) Increasing the financial stability of low-income families.

“(20) Increasing the independence and employability of individuals who are physically or mentally disabled.

“(21) Other measurable outcomes defined by the State or local government that result in positive social outcomes and Federal savings.

“(c) APPLICATION REQUIRED.—The notice described in subsection (a) shall require a State or local government
to submit an application for the social impact partnership project that addresses the following:

“(1) The outcome goals of the project.

“(2) A description of each intervention in the project and anticipated outcomes of the intervention.

“(3) Rigorous evidence demonstrating that the intervention can be expected to produce the desired outcomes.

“(4) The target population that will be served by the project.

“(5) The expected social benefits to participants who receive the intervention and others who may be impacted.

“(6) Projected Federal, State, and local government costs and other costs to conduct the project.

“(7) Projected Federal, State, and local government savings and other savings, including an estimate of the savings to the Federal Government, on a program-by-program basis and in the aggregate, if the project is implemented and the outcomes are achieved as a result of the intervention.

“(8) If savings resulting from the successful completion of the project are estimated to accrue to the State or local government, the likelihood of the State or local government to realize those savings.
“(9) A plan for delivering the intervention through a social impact partnership model.

“(10) A description of the expertise of each service provider that will administer the intervention, including a summary of the experience of the service provider in delivering the proposed intervention or a similar intervention, or demonstrating that the service provider has the expertise necessary to deliver the proposed intervention.

“(11) An explanation of the experience of the State or local government, the intermediary, or the service provider in raising private and philanthropic capital to fund social service investments.

“(12) The detailed roles and responsibilities of each entity involved in the project, including any State or local government entity, intermediary, service provider, independent evaluator, investor, or other stakeholder.

“(13) A summary of the experience of the service provider in delivering the proposed intervention or a similar intervention, or a summary demonstrating the service provider has the expertise necessary to deliver the proposed intervention.

“(14) A summary of the unmet need in the area where the intervention will be delivered or
among the target population who will receive the intervention.

“(15) The proposed payment terms, the methodology used to calculate outcome payments, the payment schedule, and performance thresholds.

“(16) The project budget.

“(17) The project timeline.

“(18) The criteria used to determine the eligibility of an individual for the project, including how selected populations will be identified, how they will be referred to the project, and how they will be enrolled in the project.

“(19) The evaluation design.

“(20) The metrics that will be used in the evaluation to determine whether the outcomes have been achieved as a result of the intervention and how the metrics will be measured.

“(21) An explanation of how the metrics used in the evaluation to determine whether the outcomes achieved as a result of the intervention are independent, objective indicators of impact and are not subject to manipulation by the service provider, intermediary, or investor.

“(22) A summary explaining the independence of the evaluator from the other entities involved in
the project and the evaluator’s experience in conducting rigorous evaluations of program effectiveness including, where available, well-implemented randomized controlled trials on the intervention or similar interventions.

“(23) The capacity of the service provider to deliver the intervention to the number of participants the State or local government proposes to serve in the project.

“(24) A description of whether and how the State or local government and service providers plan to sustain the intervention, if it is timely and appropriate to do so, to ensure that successful interventions continue to operate after the period of the social impact partnership.

“(d) PROJECT INTERMEDIARY INFORMATION REQUIRED.—The application described in subsection (c) shall also contain the following information about any intermediary for the social impact partnership project (whether an intermediary is a service provider or other entity):

“(1) Experience and capacity for providing or facilitating the provision of the type of intervention proposed.

“(2) The mission and goals.
“(3) Information on whether the intermediary is already working with service providers that provide this intervention or an explanation of the capacity of the intermediary to begin working with service providers to provide the intervention.

“(4) Experience working in a collaborative environment across government and nongovernmental entities.

“(5) Previous experience collaborating with public or private entities to implement evidence-based programs.

“(6) Ability to raise or provide funding to cover operating costs (if applicable to the project).

“(7) Capacity and infrastructure to track outcomes and measure results, including—

“(A) capacity to track and analyze program performance and assess program impact; and

“(B) experience with performance-based awards or performance-based contracting and achieving project milestones and targets.

“(8) Role in delivering the intervention.

“(9) How the intermediary would monitor program success, including a description of the interim benchmarks and outcome measures.
“(e) Feasibility Studies Funded Through Other Sources.—The notice described in subsection (a) shall permit a State or local government to submit an application for social impact partnership funding that contains information from a feasibility study developed for purposes other than applying for funding under this subtitle.

“AWARDING SOCIAL IMPACT PARTNERSHIP AGREEMENTS

“Sec. 2053. (a) Timeline in Awarding Agreement.—Not later than 6 months after receiving an application in accordance with section 2052, the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships, shall determine whether to enter into an agreement for a social impact partnership project with a State or local government.

“(b) Considerations in Awarding Agreement.—In determining whether to enter into an agreement for a social impact partnership project (the application for which was submitted under section 2052) the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships and the head of any Federal agency administering a similar intervention or serving a population similar to that served by the project, shall consider each of the following:

“(1) The recommendations made by the Commission on Social Impact Partnerships.
“(2) The value to the Federal Government of the outcomes expected to be achieved if the outcomes specified in the agreement are achieved as a result of the intervention.

“(3) The likelihood, based on evidence provided in the application and other evidence, that the State or local government in collaboration with the intermediary and the service providers will achieve the outcomes.

“(4) The savings to the Federal Government if the outcomes specified in the agreement are achieved as a result of the intervention.

“(5) The savings to the State and local governments if the outcomes specified in the agreement are achieved as a result of the intervention.

“(6) The expected quality of the evaluation that would be conducted with respect to the agreement.

“(7) The capacity and commitment of the State or local government to sustain the intervention, if appropriate and timely and if the intervention is successful, beyond the period of the social impact partnership.

“(c) AGREEMENT AUTHORITY.—

“(1) AGREEMENT REQUIREMENTS.—In accordance with this section, the Secretary, in consultation
with the Federal Interagency Council on Social Impact Partnerships and the head of any Federal agency administering a similar intervention or serving a population similar to that served by the project, may enter into an agreement for a social impact partnership project with a State or local government if the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships, determines that each of the following requirements are met:

“(A) The State or local government agrees to achieve one or more outcomes as a result of the intervention, as specified in the agreement and validated by independent evaluation, in order to receive payment.

“(B) The Federal payment to the State or local government for each specified outcome achieved as a result of the intervention is less than or equal to the value of the outcome to the Federal Government over a period not to exceed 10 years, as determined by the Secretary, in consultation with the State or local government.

“(C) The duration of the project does not exceed 10 years.
“(D) The State or local government has demonstrated, through the application submitted under section 2052, that, based on prior rigorous experimental evaluations or rigorous quasi-experimental studies, the intervention can be expected to achieve each outcome specified in the agreement.

“(E) The State, local government, intermediary, or service provider has experience raising private or philanthropic capital to fund social service investments (if applicable to the project).

“(F) The State or local government has shown that each service provider has experience delivering the intervention, a similar intervention, or has otherwise demonstrated the expertise necessary to deliver the intervention.

“(2) PAYMENT.—The Secretary shall pay the State or local government only if the independent evaluator described in section 2055 determines that the social impact partnership project has met the requirements specified in the agreement and achieved an outcome as a result of the intervention, as specified in the agreement and validated by independent evaluation.
“(d) Notice of Agreement Award.—Not later than 30 days after entering into an agreement under this section the Secretary shall publish a notice in the Federal Register that includes, with regard to the agreement, the following:

“(1) The outcome goals of the social impact partnership project.

“(2) A description of each intervention in the project.

“(3) The target population that will be served by the project.

“(4) The expected social benefits to participants who receive the intervention and others who may be impacted.

“(5) The detailed roles, responsibilities, and purposes of each Federal, State, or local government entity, intermediary, service provider, independent evaluator, investor, or other stakeholder.

“(6) The payment terms, the methodology used to calculate outcome payments, the payment schedule, and performance thresholds.

“(7) The project budget.

“(8) The project timeline.

“(9) The project eligibility criteria.

“(10) The evaluation design.
“(11) The metrics that will be used in the evaluation to determine whether the outcomes have been achieved as a result of each intervention and how these metrics will be measured.

“(12) The estimate of the savings to the Federal, State, and local government, on a program-by-program basis and in the aggregate, if the agreement is entered into and implemented and the outcomes are achieved as a result of each intervention.

“(e) AUTHORITY TO TRANSFER ADMINISTRATION OF AGREEMENT.—The Secretary may transfer to the head of another Federal agency the authority to administer (including making payments under) an agreement entered into under subsection (c), and any funds necessary to do so.

“(f) REQUIREMENT ON FUNDING USED TO BENEFIT CHILDREN.—Not less than 50 percent of all Federal payments made to carry out agreements under this section shall be used for initiatives that directly benefit children.

“FEASIBILITY STUDY FUNDING

“SEC. 2054. (a) REQUESTS FOR FUNDING FOR FEASIBILITY STUDIES.—The Secretary shall reserve a portion of the amount made available to carry out this subtitle to assist States or local governments in developing feasibility studies to apply for social impact partnership funding under section 2052. To be eligible to receive funding
to assist with completing a feasibility study, a State or local government shall submit an application for feasibility study funding addressing the following:

“(1) A description of the outcome goals of the social impact partnership project.

“(2) A description of the intervention, including anticipated program design, target population, an estimate regarding the number of individuals to be served, and setting for the intervention.

“(3) Evidence to support the likelihood that the intervention will produce the desired outcomes.

“(4) A description of the potential metrics to be used.

“(5) The expected social benefits to participants who receive the intervention and others who may be impacted.

“(6) Estimated costs to conduct the project.

“(7) Estimates of Federal, State, and local government savings and other savings if the project is implemented and the outcomes are achieved as a result of each intervention.

“(8) An estimated timeline for implementation and completion of the project, which shall not exceed 10 years.
“(9) With respect to a project for which the State or local government selects an intermediary to operate the project, any partnerships needed to successfully execute the project and the ability of the intermediary to foster the partnerships.

“(10) The expected resources needed to complete the feasibility study for the State or local government to apply for social impact partnership funding under section 2052.

“(b) Federal Selection of Applications for Feasibility Study.—Not later than 6 months after receiving an application for feasibility study funding under subsection (a), the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships and the head of any Federal agency administering a similar intervention or serving a population similar to that served by the project, shall select State or local government feasibility study proposals for funding based on the following:

“(1) The recommendations made by the Commission on Social Impact Partnerships.

“(2) The likelihood that the proposal will achieve the desired outcomes.

“(3) The value of the outcomes expected to be achieved as a result of each intervention.
“(4) The potential savings to the Federal Government if the social impact partnership project is successful.

“(5) The potential savings to the State and local governments if the project is successful.

“(c) PUBLIC DISCLOSURE.—Not later than 30 days after selecting a State or local government for feasibility study funding under this section, the Secretary shall cause to be published on the website of the Federal Interagency Council on Social Impact Partnerships information explaining why a State or local government was granted feasibility study funding.

“(d) FUNDING RESTRICTION.—

“(1) Feasibility study restriction.—The Secretary may not provide feasibility study funding under this section for more than 50 percent of the estimated total cost of the feasibility study reported in the State or local government application submitted under subsection (a).

“(2) Aggregate restriction.—Of the total amount made available to carry out this subtitle, the Secretary may not use more than $10,000,000 to provide feasibility study funding to States or local governments under this section.
“(3) No Guarantee of Funding.—The Secretary shall have the option to award no funding under this section.

“(e) Submission of Feasibility Study Required.—Not later than 9 months after the receipt of feasibility study funding under this section, a State or local government receiving the funding shall complete the feasibility study and submit the study to the Federal Interagency Council on Social Impact Partnerships.

“(f) Delegation of Authority.—The Secretary may transfer to the head of another Federal agency the authorities provided in this section and any funds necessary to exercise the authorities.

“Evaluations

“Sec. 2055. (a) Authority to Enter Into Agreements.—For each State or local government awarded a social impact partnership project approved by the Secretary under this subtitle, the head of the relevant agency, as recommended by the Federal Interagency Council on Social Impact Partnerships and determined by the Secretary, shall enter into an agreement with the State or local government to pay for all or part of the independent evaluation to determine whether the State or local government project has achieved a specific outcome as a result of the intervention in order for the State or local
government to receive outcome payments under this subtitle.

“(b) EVALUATOR QUALIFICATIONS.—The head of the relevant agency may not enter into an agreement with a State or local government unless the head determines that the evaluator is independent of the other parties to the agreement and has demonstrated substantial experience in conducting rigorous evaluations of program effectiveness including, where available and appropriate, well-implemented randomized controlled trials on the intervention or similar interventions.

“(c) METHODOLOGIES TO BE USED.—The evaluation used to determine whether a State or local government will receive outcome payments under this subtitle shall use experimental designs using random assignment or other reliable, evidence-based research methodologies, as certified by the Federal Interagency Council on Social Impact Partnerships, that allow for the strongest possible causal inferences when random assignment is not feasible.

“(d) PROGRESS REPORT.—

“(1) SUBMISSION OF REPORT.—The independent evaluator shall—

“(A) not later than 2 years after a project has been approved by the Secretary and biannually thereafter until the project is concluded,
submit to the head of the relevant agency and
the Federal Interagency Council on Social Im-
pact Partnerships a written report summarizing
the progress that has been made in achieving
each outcome specified in the agreement; and

“(B) before the scheduled time of the first
outcome payment and before the scheduled time
of each subsequent payment, submit to the
head of the relevant agency and the Federal
Interagency Council on Social Impact Partner-
ships a written report that includes the results
of the evaluation conducted to determine wheth-
er an outcome payment should be made along
with information on the unique factors that
contributed to achieving or failing to achieve
the outcome, the challenges faced in attempting
to achieve the outcome, and information on the
improved future delivery of this or similar inter-
ventions.

“(2) Submission to the Secretary and
Congress.—Not later than 30 days after receipt of
the written report pursuant to paragraph (1)(B), the
Federal Interagency Council on Social Impact Part-
nerships shall submit the report to the Secretary
and each committee of jurisdiction in the House of Representatives and the Senate.

“(e) Final Report.—

“(1) Submission of report.—Within 6 months after the social impact partnership project is completed, the independent evaluator shall—

“(A) evaluate the effects of the activities undertaken pursuant to the agreement with regard to each outcome specified in the agreement; and

“(B) submit to the head of the relevant agency and the Federal Interagency Council on Social Impact Partnerships a written report that includes the results of the evaluation and the conclusion of the evaluator as to whether the State or local government has fulfilled each obligation of the agreement, along with information on the unique factors that contributed to the success or failure of the project, the challenges faced in attempting to achieve the outcome, and information on the improved future delivery of this or similar interventions.

“(2) Submission to the Secretary and Congress.—Not later than 30 days after receipt of the written report pursuant to paragraph (1)(B), the
Federal Interagency Council on Social Impact Partnerships shall submit the report to the Secretary and each committee of jurisdiction in the House of Representatives and the Senate.

“(f) LIMITATION ON COST OF EVALUATIONS.—Of the amount made available under this subtitle for social impact partnership projects, the Secretary may not obligate more than 15 percent to evaluate the implementation and outcomes of the projects.

“(g) DELEGATION OF AUTHORITY.—The Secretary may transfer to the head of another Federal agency the authorities provided in this section and any funds necessary to exercise the authorities.

“FEDERAL INTERAGENCY COUNCIL ON SOCIAL IMPACT PARTNERSHIPS

“Sec. 2056. (a) Establishment.—There is established the Federal Interagency Council on Social Impact Partnerships (in this section referred to as the ‘Council’) to—

“(1) coordinate with the Secretary on the efforts of social impact partnership projects funded under this subtitle;

“(2) advise and assist the Secretary in the development and implementation of the projects;

“(3) advise the Secretary on specific programmatic and policy matter related to the projects;
“(4) provide subject-matter expertise to the Secretary with regard to the projects;

“(5) certify to the Secretary that each State or local government that has entered into an agreement with the Secretary for a social impact partnership project under this subtitle and each evaluator selected by the head of the relevant agency under section 2055 has access to Federal administrative data to assist the State or local government and the evaluator in evaluating the performance and outcomes of the project;

“(6) address issues that will influence the future of social impact partnership projects in the United States;

“(7) provide guidance to the executive branch on the future of social impact partnership projects in the United States;

“(8) prior to approval by the Secretary, certify that each State and local government application for a social impact partnership contains rigorous, independent data and reliable, evidence-based research methodologies to support the conclusion that the project will yield savings to the State or local government or the Federal Government if the project outcomes are achieved;
“(9) certify to the Secretary, in the case of each approved social impact partnership that is expected to yield savings to the Federal Government, that the project will yield a projected savings to the Federal Government if the project outcomes are achieved, and coordinate with the relevant Federal agency to produce an after-action accounting once the project is complete to determine the actual Federal savings realized, and the extent to which actual savings aligned with projected savings; and

“(10) provide periodic reports to the Secretary and make available reports periodically to Congress and the public on the implementation of this sub-title.

“(b) COMPOSITION OF COUNCIL.—The Council shall have 11 members, as follows:

“(1) CHAIR.—The Chair of the Council shall be the Director of the Office of Management and Budget.

“(2) OTHER MEMBERS.—The head of each of the following entities shall designate one officer or employee of the entity to be a Council member:

“(A) The Department of Labor.

“(B) The Department of Health and Human Services.
“(C) The Social Security Administration.
“(D) The Department of Agriculture.
“(E) The Department of Justice.
“(F) The Department of Housing and Urban Development.
“(G) The Department of Education.
“(H) The Department of Veterans Affairs.
“(I) The Department of the Treasury.
“(J) The Corporation for National and Community Service.

COMMISSION ON SOCIAL IMPACT PARTNERSHIPS

SEC. 2057. (a) ESTABLISHMENT.—There is established the Commission on Social Impact Partnerships (in this section referred to as the ‘Commission’).

“(b) DUTIES.—The duties of the Commission shall be to—

“(1) assist the Secretary and the Federal Interagency Council on Social Impact Partnerships in reviewing applications for funding under this subtitle;

“(2) make recommendations to the Secretary and the Federal Interagency Council on Social Impact Partnerships regarding the funding of social impact partnership agreements and feasibility studies; and
“(3) provide other assistance and information as requested by the Secretary or the Federal Inter-agency Council on Social Impact Partnerships.

“(c) COMPOSITION.—The Commission shall be composed of nine members, of whom—

“(1) one shall be appointed by the President, who will serve as the Chair of the Commission;

“(2) one shall be appointed by the Majority Leader of the Senate;

“(3) one shall be appointed by the Minority Leader of the Senate;

“(4) one shall be appointed by the Speaker of the House of Representatives;

“(5) one shall be appointed by the Minority Leader of the House of Representatives;

“(6) one shall be appointed by the Chairman of the Committee on Finance of the Senate;

“(7) one shall be appointed by the ranking member of the Committee on Finance of the Senate;

“(8) one member shall be appointed by the Chairman of the Committee on Ways and Means of the House of Representatives; and

“(9) one shall be appointed by the ranking member of the Committee on Ways and Means of the House of Representatives.
“(d) QUALIFICATIONS OF COMMISSION MEMBERS.—

The members of the Commission shall—

“(1) be experienced in finance, economics, pay
for performance, or program evaluation;

“(2) have relevant professional or personal ex-
perience in a field related to one or more of the out-
comes listed in this subtitle; or

“(3) be qualified to review applications for so-
cial impact partnership projects to determine wheth-
er the proposed metrics and evaluation methodolo-
gies are appropriately rigorous and reliant upon
independent data and evidence-based research.

“(e) TIMING OF APPOINTMENTS.—The appointments
of the members of the Commission shall be made not later
than 120 days after the date of the enactment of this sub-
title, or, in the event of a vacancy, not later than 90 days
after the date the vacancy arises. If a member of Congress
fails to appoint a member by that date, the President may
select a member of the President’s choice on behalf of the
member of Congress. Notwithstanding the preceding sen-
tence, if not all appointments have been made to the Com-
mission as of that date, the Commission may operate with
no fewer than five members until all appointments have
been made.

“(f) TERM OF APPOINTMENTS.—
“(1) In general.—The members appointed under subsection (c) shall serve as follows:

“(A) Three members shall serve for 2 years.

“(B) Three members shall serve for 3 years.

“(C) Three members (one of which shall be Chair of the Commission appointed by the President) shall serve for 4 years.

“(2) Assignment of terms.—The Commission shall designate the term length that each member appointed under subsection (c) shall serve by unanimous agreement. In the event that unanimous agreement cannot be reached, term lengths shall be assigned to the members by a random process.

“(g) Vacancies.—Subject to subsection (e), in the event of a vacancy in the Commission, whether due to the resignation of a member, the expiration of a member’s term, or any other reason, the vacancy shall be filled in the manner in which the original appointment was made and shall not affect the powers of the Commission.

“(h) Appointment power.—Members of the Commission appointed under subsection (c) shall not be subject to confirmation by the Senate.
“LIMITATION ON USE OF FUNDS

“Sec. 2058. Of the amounts made available to carry out this subtitle, the Secretary may not use more than $2,000,000 in any fiscal year to support the review, approval, and oversight of social impact partnership projects, including activities conducted by—

“(1) the Federal Interagency Council on Social Impact Partnerships; and

“(2) any other agency consulted by the Secretary before approving a social impact partnership project or a feasibility study under section 2054.

“NO FEDERAL FUNDING FOR CREDIT ENHANCEMENTS

“Sec. 2059. No amount made available to carry out this subtitle may be used to provide any insurance, guarantee, or other credit enhancement to a State or local government under which a Federal payment would be made to a State or local government as the result of a State or local government failing to achieve an outcome specified in an agreement.

“AVAILABILITY OF FUNDS

“Sec. 2060. Amounts made available to carry out this subtitle shall remain available until 10 years after the date of the enactment of this subtitle.
“SEC. 2061. The Federal Interagency Council on Social Impact Partnerships shall establish and maintain a public website that shall display the following:

“(1) A copy of, or method of accessing, each notice published regarding a social impact partnership project pursuant to this subtitle.

“(2) A copy of each feasibility study funded under this subtitle.

“(3) For each State or local government that has entered into an agreement with the Secretary for a social impact partnership project, the website shall contain the following information:

“(A) The outcome goals of the project.

“(B) A description of each intervention in the project.

“(C) The target population that will be served by the project.

“(D) The expected social benefits to participants who receive the intervention and others who may be impacted.

“(E) The detailed roles, responsibilities, and purposes of each Federal, State, or local government entity, intermediary, service pro-
vider, independent evaluator, investor, or other stakeholder.

“(F) The payment terms, methodology used to calculate outcome payments, the payment schedule, and performance thresholds.

“(G) The project budget.

“(H) The project timeline.

“(I) The project eligibility criteria.

“(J) The evaluation design.

“(K) The metrics used to determine whether the proposed outcomes have been achieved and how these metrics are measured.

“(4) A copy of the progress reports and the final reports relating to each social impact partnership project.

“(5) An estimate of the savings to the Federal, State, and local government, on a program-by-program basis and in the aggregate, resulting from the successful completion of the social impact partnership project.

“REGULATIONS

“SEC. 2062. The Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships, may issue regulations as necessary to carry out this subtitle.
DEFINITIONS

"SEC. 2063. In this subtitle:

(1) AGENCY.—The term ‘agency’ has the meaning given that term in section 551 of title 5, United States Code.

(2) INTERVENTION.—The term ‘intervention’ means a specific service delivered to achieve an impact through a social impact partnership project.

(3) SECRETARY.—The term ‘Secretary’ means the Secretary of the Treasury.

(4) SOCIAL IMPACT PARTNERSHIP PROJECT.—The term ‘social impact partnership project’ means a project that finances social services using a social impact partnership model.

(5) SOCIAL IMPACT PARTNERSHIP MODEL.—The term ‘social impact partnership model’ means a method of financing social services in which—

(A) Federal funds are awarded to a State or local government only if a State or local government achieves certain outcomes agreed on by the State or local government and the Secretary; and

(B) the State or local government coordinates with service providers, investors (if appli-
cable to the project), and (if necessary) an intermediary to identify—

“(i) an intervention expected to produce the outcome;

“(ii) a service provider to deliver the intervention to the target population; and

“(iii) investors to fund the delivery of the intervention.

“(6) STATE.—The term ‘State’ means each State of the United States, the District of Columbia, each commonwealth, territory or possession of the United States, and each federally recognized Indian tribe.

“FUNDING

“SEC. 2064. Out of any money in the Treasury of the United States not otherwise appropriated, there is hereby appropriated $100,000,000 for fiscal year 2018 to carry out this subtitle.”.

TITLE IX—PUBLIC HEALTH PROGRAMS

SEC. 50901. EXTENSION FOR COMMUNITY HEALTH CENTERS, THE NATIONAL HEALTH SERVICE CORPS, AND TEACHING HEALTH CENTERS THAT OPERATE GME PROGRAMS.

(a) COMMUNITY HEALTH CENTERS FUNDING.—Sec-
able Care Act (42 U.S.C. 254b–2(b)(1)(F)), as amended by section 3101 of Public Law 115-96, is amended to read as follows:

“(F) $3,800,000,000 for fiscal year 2018 and $4,000,000,000 for fiscal year 2019.”.

(b) Other Community Health Centers Provisions.—Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) in subsection (b)(1)(A)(ii), by striking “abuse” and inserting “use disorder”;

(2) in subsection (b)(2)(A), by striking “abuse” and inserting “use disorder”;

(3) in subsection (c)—

(A) in paragraph (1), by striking subparagraphs (B) through (D);

(B) by striking “(1) IN GENERAL” and all that follows through “The Secretary” and inserting the following:

“(1) CENTERS.—The Secretary”; and

(C) in paragraph (1), as amended, by redesignating clauses (i) through (v) as subparagraphs (A) through (E) and moving the margin of each of such redesignated subparagraph 2 ems to the left;
(4) by striking subsection (d) and inserting the following:

“(d) IMPROVING QUALITY OF CARE.—

“(1) SUPPLEMENTAL AWARDS.—The Secretary may award supplemental grant funds to health centers funded under this section to implement evidence-based models for increasing access to high-quality primary care services, which may include models related to—

“(A) improving the delivery of care for individuals with multiple chronic conditions;

“(B) workforce configuration;

“(C) reducing the cost of care;

“(D) enhancing care coordination;

“(E) expanding the use of telehealth and technology-enabled collaborative learning and capacity building models;

“(F) care integration, including integration of behavioral health, mental health, or substance use disorder services; and

“(G) addressing emerging public health or substance use disorder issues to meet the health needs of the population served by the health center.
“(2) SUSTAINABILITY.—In making supplemental awards under this subsection, the Secretary may consider whether the health center involved has submitted a plan for continuing the activities funded under this subsection after supplemental funding is expended.

“(3) SPECIAL CONSIDERATION.—The Secretary may give special consideration to applications for supplemental funding under this subsection that seek to address significant barriers to access to care in areas with a greater shortage of health care providers and health services relative to the national average.”;

(5) in subsection (e)(1)—

(A) in subparagraph (B)—

(i) by striking “2 years” and inserting “1 year”; and

(ii) by adding at the end the following: “The Secretary shall not make a grant under this paragraph unless the applicant provides assurances to the Secretary that within 120 days of receiving grant funding for the operation of the health center, the applicant will submit, for approval by the Secretary, an implementa-
tion plan to meet the requirements of sub-
section (k)(3). The Secretary may extend
such 120-day period for achieving compli-
ance upon a demonstration of good cause
by the health center.”; and
(B) in subparagraph (C)—
(i) in the subparagraph heading, by
striking “AND PLANS”;
(ii) by striking “or plan (as described
in subparagraphs (B) and (C) of sub-
section (c)(1))”;
(iii) by striking “or plan, including
the purchase” and inserting the following:
“including—
“(i) the purchase”;
(iv) by inserting “, which may include
data and information systems” after “of
equipment”;
(v) by striking the period at the end
and inserting a semicolon; and
(vi) by adding at the end the fol-
lowing:
“(ii) the provision of training and
technical assistance; and
“(iii) other activities that—
“(I) reduce costs associated with the provision of health services;

“(II) improve access to, and availability of, health services provided to individuals served by the centers;

“(III) enhance the quality and coordination of health services; or

“(IV) improve the health status of communities.”;

(6) in subsection (e)(5)(B)—

(A) in the heading of subparagraph (B), by striking “AND PLANS”; and

(B) by striking “and subparagraphs (B) and (C) of subsection (e)(1) to a health center or to a network or plan” and inserting “to a health center or to a network”;

(7) in subsection (e), by adding at the end the following:

“(6) NEW ACCESS POINTS AND EXPANDED SERVICES.—

“(A) APPROVAL OF NEW ACCESS POINTS.—

“(i) IN GENERAL.—The Secretary may approve applications for grants under
subparagraph (A) or (B) of paragraph (1) to establish new delivery sites.

“(ii) Special consideration.—In carrying out clause (i), the Secretary may give special consideration to applicants that have demonstrated the new delivery site will be located within a sparsely populated area, or an area which has a level of unmet need that is higher relative to other applicants.

“(iii) Consideration of applications.—In carrying out clause (i), the Secretary shall approve applications for grants in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by the applicants involved to the medically underserved populations in urban areas which may be expected to use the services provided by the applicants is not less than two to three or greater than three to two.

“(iv) Service area overlap.—If in carrying out clause (i) the applicant proposes to serve an area that is currently
served by another health center funded under this section, the Secretary may consider whether the award of funding to an additional health center in the area can be justified based on the unmet need for additional services within the catchment area.

"(B) APPROVAL OF EXPANDED SERVICE APPLICATIONS.—

"(i) IN GENERAL.—The Secretary may approve applications for grants under subparagraph (A) or (B) of paragraph (1) to expand the capacity of the applicant to provide required primary health services described in subsection (b)(1) or additional health services described in subsection (b)(2).

"(ii) PRIORITY EXPANSION PROJECTS.—In carrying out clause (i), the Secretary may give special consideration to expanded service applications that seek to address emerging public health or behavioral health, mental health, or substance abuse issues through increasing the availability of additional health services described in subsection (b)(2) in an area in
which there are significant barriers to accessing care.

“(iii) CONSIDERATION OF APPLICATIONS.—In carrying out clause (i), the Secretary shall approve applications for grants in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by the applicants involved to the medically underserved populations in urban areas which may be expected to use the services provided by such applicants is not less than two to three or greater than three to two.”;

(8) in subsection (h)—

(A) in paragraph (1), by striking “and children and youth at risk of homelessness” and inserting “, children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness”; and

(B) in paragraph (5)—

(i) by striking subparagraph (B); and

(ii) by redesignating subparagraph (C) as subparagraph (B); and
(iii) in subparagraph (B) (as so redesignated)—

(I) in the subparagraph heading,

by striking “ABUSE” and inserting “USE DISORDER”; and

(II) by striking “abuse” and inserting “use disorder”;

(9) in subsection (k)—

(A) in paragraph (2)—

(i) in the paragraph heading, by inserting “UNMET” before “NEED”;

(ii) in the matter preceding subparagraph (A), by inserting “or subsection (e)(6)” after “subsection (e)(1)”;

(iii) in subparagraph (A), by inserting “unmet” before “need for health services”;

(iv) in subparagraph (B), by striking “and” at the end;

(v) in subparagraph (C), by striking the period at the end and inserting “; and”;

(vi) by adding after subparagraph (C) the following:

“(D) in the case of an application for a grant pursuant to subsection (e)(6), a dem-
onstration that the applicant has consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed delivery site.”;

(B) in paragraph (3)—

(i) in the matter preceding subpara-

graph (A), by inserting “or subsection (e)(6)” after “subsection (e)(1)(B)”;

(ii) in subparagraph (B), by striking “in the catchment area of the center” and inserting “, including other health care providers that provide care within the catchment area, local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments”;

(iii) in subparagraph (H)(ii), by in-

serting “who shall be directly employed by the center” after “approves the selection of a director for the center”;

(iv) in subparagraph (L), by striking “and” at the end;
(v) in subparagraph (M), by striking the period and inserting ‘‘; and’’; and

(vi) by inserting after subparagraph (M), the following:

‘‘(N) the center has written policies and procedures in place to ensure the appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award.’’;

and

(C) by striking paragraph (4);

(10) in subsection (l), by adding at the end the following: ‘‘Funds expended to carry out activities under this subsection and operational support activities under subsection (m) shall not exceed 3 percent of the amount appropriated for this section for the fiscal year involved.’’;

(11) in subsection (q)(4), by adding at the end the following: ‘‘A waiver provided by the Secretary under this paragraph may not remain in effect for more than 1 year and may not be extended after such period. An entity may not receive more than one waiver under this paragraph in consecutive years.’’;

(12) in subsection (r)(3)—
(A) by striking “appropriate committees of Congress a report concerning the distribution of funds under this section” and inserting the following: “Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives, a report including, at a minimum—

“(A) the distribution of funds for carrying out this section’’;

(B) by striking “populations. Such report shall include an assessment” and inserting the following: “populations;

“(B) an assessment’’;

(C) by striking “and the rationale for any substantial changes in the distribution of funds.” and inserting a semicolon; and

(D) by adding at the end the following:

“(C) the distribution of awards and funding for new or expanded services in each of rural areas and urban areas;

“(D) the distribution of awards and funding for establishing new access points, and the number of new access points created;
“(E) the amount of unexpended funding for loan guarantees and loan guarantee authority under title XVI;

“(F) the rationale for any substantial changes in the distribution of funds;

“(G) the rate of closures for health centers and access points;

“(H) the number and reason for any grants awarded pursuant to subsection (e)(1)(B); and

“(I) the number and reason for any waivers provided pursuant to subsection (q)(4).”;

(13) in subsection (r), by adding at the end the following new paragraph:

“(5) FUNDING FOR PARTICIPATION OF HEALTH CENTERS IN ALL OF US RESEARCH PROGRAM.—In addition to any amounts made available pursuant to paragraph (1) of this subsection, section 402A of this Act, or section 10503 of the Patient Protection and Affordable Care Act, there is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the Secretary $25,000,000 for fiscal year 2018 to support the participation of health centers in the All
of Us Research Program under the Precision Medicine Initiative under section 498E of this Act’’; and
(14) by striking subsection (s).

(c) National Health Service Corps.—Section 10503(b)(2)(F) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(2)(F)), as amended by section 3101 of Public Law 115-96, is amended to read as follows:

‘‘(F) $310,000,000 for each of fiscal years 2018 and 2019.’’.

(d) Teaching Health Centers That Operate Graduate Medical Education Programs.—

(1) Payments.—Subsection (a) of section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended to read as follows:

‘‘(a) Payments.—

‘‘(1) In general.—Subject to subsection (h)(2), the Secretary shall make payments under this section for direct expenses and indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for, as appropriate—

‘‘(A) maintenance of filled positions at existing approved graduate medical residency training programs;
“(B) expansion of existing approved graduate medical residency training programs; and

“(C) establishment of new approved graduate medical residency training programs.

“(2) PER RESIDENT AMOUNT.—In making payments under paragraph (1), the Secretary shall consider the cost 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.

“(3) PRIORITY.—In making payments under paragraph (1)(C), the Secretary shall give priority to qualified teaching health centers that—

“(A) serve a health professional shortage area with a designation in effect under section 332 or a medically underserved community (as defined in section 799B); or

“(B) are located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act).”.

(2) FUNDING.—Paragraph (1) of section 340H(g) of the Public Health Service Act (42 U.S.C. 256h(g)), as amended by section 3101 of Public Law 115-96, is amended by striking “and $30,000,000 for the period of the first and second
quarters of fiscal year 2018,” and inserting “and
$126,500,000 for each of fiscal years 2018 and
2019.”.

(3) ANNUAL REPORTING.—Subsection (h)(1) of
section 340H of the Public Health Service Act (42
U.S.C. 256h) is amended—

(A) by redesignating subparagraph (D) as
subparagraph (H); and

(B) by inserting after subparagraph (C)
the following:

“(D) The number of patients treated by
residents described in paragraph (4).

“(E) The number of visits by patients
treated by residents described in paragraph (4).

“(F) Of the number of residents described
in paragraph (4) who completed their residency
training at the end of such residency academic
year, the number and percentage of such resi-
dents entering primary care practice (meaning
any of the areas of practice listed in the defini-
tion of a primary care residency program in
section 749A).

“(G) Of the number of residents described
in paragraph (4) who completed their residency
training at the end of such residency academic
year, the number and percentage of such residents who entered practice at a health care facility—

“(i) primarily serving a health professional shortage area with a designation in effect under section 332 or a medically underserved community (as defined in section 799B); or

“(ii) located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act).”.

(4) REPORT ON TRAINING COSTS.—Not later than March 31, 2019, the Secretary of Health and Human Services shall submit to the Congress a report on the direct graduate expenses of approved graduate medical residency training programs, and the indirect expenses associated with the additional costs of teaching residents, of qualified teaching health centers (as such terms are used or defined in section 340H of the Public Health Service Act (42 U.S.C. 256h)).

(5) DEFINITION.—Subsection (j) of section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended—
(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(B) by inserting after paragraph (1) the following:

“(2) NEW APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term ‘new approved graduate medical residency training program’ means an approved graduate medical residency training program for which the sponsoring qualified teaching health center has not received a payment under this section for a previous fiscal year (other than pursuant to subsection (a)(1)(C)).”.

(6) TECHNICAL CORRECTION.—Subsection (f) of section 340H (42 U.S.C. 256h) is amended by striking “hospital” each place it appears and inserting “teaching health center”.

(7) PAYMENTS FOR PREVIOUS FISCAL YEARS.—The provisions of section 340H of the Public Health Service Act (42 U.S.C. 256h), as in effect on the day before the date of enactment of Public Law 115-96, shall continue to apply with respect to payments under such section for fiscal years before fiscal year 2018.

(c) APPLICATION.—Amounts appropriated pursuant to this section for fiscal year 2018 or 2019 are subject
to the requirements contained in Public Law 115–31 for funds for programs authorized under sections 330 through 340 of the Public Health Service Act (42 U.S.C. 254b–256).

(f) Conforming Amendments.—Paragraph (4) of section 3014(h) of title 18, United States Code, as amended by section 3101 of Public Law 115-96, is amended by striking “and section 3101(d) of the CHIP and Public Health Funding Extension Act” and inserting “and section 50901(e) of the Advancing Chronic Care, Extenders, and Social Services Act’’.

SEC. 50902. EXTENSION FOR SPECIAL DIABETES PROGRAMS.

(a) Special Diabetes Program for Type I Diabetes.—Section 330B(b)(2)(D) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(D)), as amended by section 3102 of Public Law 115-96, is amended to read as follows:

“(D) $150,000,000 for each of fiscal years 2018 and 2019, to remain available until expended.”.

(b) Special Diabetes Program for Indians.—Subparagraph (D) of section 330C(e)(2) of the Public Health Service Act (42 U.S.C. 254c–3(e)(2)), as amended
by section 3102 of Public Law 115-96, is amended to read as follows:

“(D) $150,000,000 for each of fiscal years 2018 and 2019, to remain available until expended.”.

**TITLE X—MISCELLANEOUS HEALTH CARE POLICIES**

**SEC. 51001. HOME HEALTH PAYMENT REFORM.**

(a) **Budget Neutral Transition to a 30-day Unit of Payment for Home Health Services.**—Section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) is amended—

(1) in paragraph (2)—

(A) by striking “PAYMENT.—In defining” and inserting “PAYMENT.—

“(A) IN GENERAL.—In defining”; and

(B) by adding at the end the following new subparagraph:

“(B) 30-DAY UNIT OF SERVICE.—For purposes of implementing the prospective payment system with respect to home health units of service furnished during a year beginning with 2020, the Secretary shall apply a 30-day unit of service as the unit of service applied under this paragraph.”;
(2) in paragraph (3)—

(A) in subparagraph (A), by adding at the end the following new clause:

“(iv) BUDGET NEUTRALITY FOR 2020.—With respect to payments for home health units of service furnished that end during the 12-month period beginning January 1, 2020, the Secretary shall calculate a standard prospective payment amount (or amounts) for 30-day units of service (as described in paragraph (2)(B)) for the prospective payment system under this subsection. Such standard prospective payment amount (or amounts) shall be calculated in a manner such that the estimated aggregate amount of expenditures under the system during such period with application of paragraph (2)(B) is equal to the estimated aggregate amount of expenditures that otherwise would have been made under the system during such period if paragraph (2)(B) had not been enacted. The previous sentence shall be applied before (and not affect the application of) paragraph (3)(B). In calculating such
amount (or amounts), the Secretary shall make assumptions about behavior changes that could occur as a result of the implementation of paragraph (2)(B) and the case-mix adjustment factors established under paragraph (4)(B) and shall provide a description of such assumptions in the notice and comment rulemaking used to implement this clause.’’; and (B) by adding at the end the following new subparagraph:

“(D) BEHAVIOR ASSUMPTIONS AND ADJUSTMENTS.—

“(i) IN GENERAL.—The Secretary shall annually determine the impact of differences between assumed behavior changes (as described in paragraph (3)(A)(iv)) and actual behavior changes on estimated aggregate expenditures under this subsection with respect to years beginning with 2020 and ending with 2026.

“(ii) PERMANENT ADJUSTMENTS.—The Secretary shall, at a time and in a manner determined appropriate, through notice and comment rulemaking, provide
for one or more permanent increases or decreases to the standard prospective payment amount (or amounts) for applicable years, on a prospective basis, to offset for such increases or decreases in estimated aggregate expenditures (as determined under clause (i)).

“(iii) Temporary adjustments for retrospective behavior.—The Secretary shall, at a time and in a manner determined appropriate, through notice and comment rulemaking, provide for one or more temporary increases or decreases to the payment amount for a unit of home health services (as determined under paragraph (4)) for applicable years, on a prospective basis, to offset for such increases or decreases in estimated aggregate expenditures (as determined under clause (i)). Such a temporary increase or decrease shall apply only with respect to the year for which such temporary increase or decrease is made, and the Secretary shall not take into account such a temporary increase or decrease in computing such
amount under this subsection for a subsequent year.”; and

(3) in paragraph (4)(B)—

(A) by striking “FACTORS.—The Secretary” and inserting “FACTORS.—

“(i) IN GENERAL.—The Secretary”; and

(B) by adding at the end the following new clause:

“(ii) TREATMENT OF THERAPY

thresholds.—For 2020 and subsequent years, the Secretary shall eliminate the use

of therapy thresholds (established by the Secretary) in case mix adjustment factors

established under clause (i) for calculating payments under the prospective payment

system under this subsection.”.

(b) TECHNICAL EXPERT PANEL.—

(1) IN GENERAL.—During the period beginning on January 1, 2018, and ending on December 31, 2018, the Secretary of Health and Human Services shall hold at least one session of a technical expert panel, the participants of which shall include home health providers, patient representatives, and other relevant stakeholders. The technical expert panel
shall identify and prioritize recommendations with respect to the prospective payment system for home health services under section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)), on the following:

(A) The Home Health Groupings Model, as described in the proposed rule “Medicare and Medicaid Programs; CY 2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements” (82 Fed. Reg. 35294 through 35332 (July 28, 2017)).

(B) Alternative case-mix models to the Home Health Groupings Model that were submitted during 2017 as comments in response to proposed rule making, including patient-focused factors that consider the risks of hospitalization and readmission to a hospital, improvement or maintenance of functionality of individuals to increase the capacity for self-care, quality of care, and resource utilization.
(2) **INAPPLICABILITY OF FACA.**—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the technical expert panel under paragraph (1).

(3) **REPORT.**—Not later than April 1, 2019, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the recommendations of such panel described in such paragraph.

(4) **NOTICE AND COMMENT RULEMAKING.**—Not later than December 31, 2019, the Secretary of Health and Human Services shall pursue notice and comment rulemaking on a case-mix system with respect to the prospective payment system for home health services under section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)).

(c) **REPORTS.**—

(1) **INTERIM REPORT.**—Not later than March 15, 2022, the Medicare Payment Advisory Commission shall submit to Congress an interim report on the application of a 30-day unit of service as the unit of service applied under section 1895(b)(2) of the Social Security Act (42 U.S.C. 1395fff(b)(2)), as
amended by subsection (a), including an analysis of
the level of payments provided to home health agen-
cies as compared to the cost of delivering home
health services, and any unintended consequences,
including with respect to behavioral changes and
quality.

(2) Final report.—Not later than March 15,
2026, such Commission shall submit to Congress a
final report on such application and any such con-
sequences.

SEC. 51002. INFORMATION TO SATISFY DOCUMENTATION
OF MEDICARE ELIGIBILITY FOR HOME
HEALTH SERVICES.

(a) Part A.—Section 1814(a) of the Social Security
Act (42 U.S.C. 1395f(a)) is amended by inserting before
“For purposes of paragraph (2)(C),” the following new
sentence: “For purposes of documentation for physician
certification and recertification made under paragraph (2)
on or after January 1, 2019, and made with respect to
home health services furnished by a home health agency,
in addition to using documentation in the medical record
of the physician who so certifies or the medical record of
the acute or post-acute care facility (in the case that home
health services were furnished to an individual who was
directly admitted to the home health agency from such a
facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved.”.

(b) PART B.—Section 1835(a) of the Social Security Act (42 U.S.C. 1395n(a)) is amended by inserting before “For purposes of paragraph (2)(A),” the following new sentence: “For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019, and made with respect to home health services furnished by a home health agency, in addition to using documentation in the medical record of the physician who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved.”.

SEC. 51003. TECHNICAL AMENDMENTS TO PUBLIC LAW 114–10.

(a) MIPS TRANSITION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (q)—

(A) in paragraph (1)—
(i) in subparagraph (B), by striking “items and services” and inserting “covered professional services (as defined in subsection (k)(3)(A))”; and

(ii) in subparagraph (C)(iv)—

(I) by amending subclause (I) to read as follows:

“(I) The minimum number (as determined by the Secretary) of—

“(aa) for performance periods beginning before January 1, 2018, individuals enrolled under this part who are treated by the eligible professional for the performance period involved; and

“(bb) for performance periods beginning on or after January 1, 2018, individuals enrolled under this part who are furnished covered professional services (as defined in subsection (k)(3)(A)) by the eligible professional for the performance period involved.”;
(II) in subclause (II), by striking “items and services” and inserting “covered professional services (as defined in subsection (k)(3)(A))”; and

(III) by amending subclause (III) to read as follows:

“(III) The minimum amount (as determined by the Secretary) of—

“(aa) for performance periods beginning before January 1, 2018, allowed charges billed by such professional under this part for such performance period; and

“(bb) for performance periods beginning on or after January 1, 2018, allowed charges for covered professional services (as defined in subsection (k)(3)(A)) billed by such professional for such performance period.”;

(B) in paragraph (5)(D)—

(i) in clause (i)(I), by inserting “subject to clause (iii),” after “clauses (i) and (ii) of paragraph (2)(A),”; and
(ii) by adding at the end the following new clause:

“(iii) TRANSITION YEARS.—For each of the second, third, fourth, and fifth years for which the MIPS applies to payments, the performance score for the performance category described in paragraph (2)(A)(ii) shall not take into account the improvement of the professional involved.”;

(C) in paragraph (5)(E)—

(i) in clause (i)(I)(bb)—

(1) in the heading by striking “FIRST 2 YEARS” and inserting “FIRST 5 YEARS”; and

(II) by striking “the first and second years” and inserting “each of the first through fifth years”;

(ii) in clause (i)(II)(bb)—

(I) in the heading, by striking “2 YEARS” and inserting “5 YEARS”; and

(II) by striking the second sentence and inserting the following new sentences: “For each of the second, third, fourth, and fifth years for which the MIPS applies to payments,
not less than 10 percent and not more than 30 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). Nothing in the previous sentence shall be construed, with respect to a performance period for a year described in the previous sentence, as preventing the Secretary from basing 30 percent of such score for such year with respect to the category described in such clause (ii), if the Secretary determines, based on information posted under subsection (r)(2)(I) that sufficient resource use measures are ready for adoption for use under the performance category under paragraph (2)(A)(ii) for such performance period.”;

(D) in paragraph (6)(D)—

(i) in clause (i), in the second sentence, by striking “Such performance threshold” and inserting “Subject to clauses (iii) and (iv), such performance threshold”;
(ii) in clause (ii)—

(I) in the first sentence, by inserting “(beginning with 2019 and ending with 2024)” after “for each year of the MIPS”; and

(II) in the second sentence, by inserting “subject to clause (iii),” after “For each such year,”;

(iii) in clause (iii)—

(I) in the heading, by striking “2” and inserting “5”; and

(II) in the first sentence, by striking “two years” and inserting “five years”; and

(iv) by adding at the end the following new clause:

“(iv) ADDITIONAL SPECIAL RULE FOR THIRD, FOURTH AND FIFTH YEARS OF MIPS.—For purposes of determining MIPS adjustment factors under subparagraph (A), in addition to the requirements specified in clause (iii), the Secretary shall increase the performance threshold with respect to each of the third, fourth, and fifth years to which the MIPS applies to ensure
a gradual and incremental transition to the performance threshold described in clause (i) (as estimated by the Secretary) with respect to the sixth year to which the MIPS applies.”

(E) in paragraph (6)(E)—

(i) by striking “In the case of items and services” and inserting “In the case of covered professional services (as defined in subsection (k)(3)(A))”; and

(ii) by striking “under this part with respect to such items and services” and inserting “under this part with respect to such covered professional services”; and

(F) in paragraph (7), in the first sentence, by striking “items and services” and inserting “covered professional services (as defined in subsection (k)(3)(A))”;

(2) in subsection (r)(2), by adding at the end the following new subparagraph:

“(I) INFORMATION.—The Secretary shall, not later than December 31st of each year (beginning with 2018), post on the Internet website of the Centers for Medicare & Medicaid Services information on resource use measures
in use under subsection (q), resource use measures under development and the time-frame for such development, potential future resource use measure topics, a description of stakeholder engagement, and the percent of expenditures under part A and this part that are covered by resource use measures.”; and

(3) in subsection (s)(5)(B), by striking “section 1833(z)(2)(C)” and inserting “section 1833(z)(3)(D)”.

(b) PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE PROVISION OF INITIAL PROPOSAL FEEDBACK.—Section 1868(c)(2)(C) of the Social Security Act (42 U.S.C. 1395ee(c)(2)(C)) is amended to read as follows:

“(C) COMMITTEE REVIEW OF MODELS SUBMITTED.—The Committee, on a periodic basis—

“(i) shall review models submitted under subparagraph (B);

“(ii) may provide individuals and stakeholder entities who submitted such models with—

“(I) initial feedback on such models regarding the extent to which
such models meet the criteria described in subparagraph (A); and

“(II) an explanation of the basis
for the feedback provided under sub-
clause (I); and

“(iii) shall prepare comments and rec-
ommendations regarding whether such
models meet the criteria described in sub-
paragraph (A) and submit such comments
and recommendations to the Secretary.”.

SEC. 51004. EXPANDED ACCESS TO MEDICARE INTENSIVE
CARDIAC REHABILITATION PROGRAMS.

Section 1861(eee)(4)(B) of the Social Security Act
(42 U.S.C. 1395x(eee)(4)(B)) is amended—

(1) in clause (v), by striking “or” at the end;

(2) in clause (vi), by striking the period at the
end and inserting a semicolon; and

(3) by adding at the end the following new
clauses:

“(vii) stable, chronic heart failure (defined
as patients with left ventricular ejection fraction
of 35 percent or less and New York Heart As-
association (NYHA) class II to IV symptoms de-
spite being on optimal heart failure therapy for
at least 6 weeks); or
“(viii) any additional condition for which the Secretary has determined that a cardiac rehabilitation program shall be covered, unless the Secretary determines, using the same process used to determine that the condition is covered for a cardiac rehabilitation program, that such coverage is not supported by the clinical evidence.”.

SEC. 51005. EXTENSION OF BLENDED SITE NEUTRAL PAYMENT RATE FOR CERTAIN LONG-TERM CARE HOSPITAL DISCHARGES; TEMPORARY ADJUSTMENT TO SITE NEUTRAL PAYMENT RATES.

(a) Extension.—Section 1886(m)(6)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(m)(6)(B)(i)) is amended—

(1) in subclause (I), by striking “fiscal year 2016 or fiscal year 2017” and inserting “fiscal years 2016 through 2019”; and

(2) in subclause (II), by striking “2018” and inserting “2020”.

(b) Temporary Adjustment to Site Neutral Payment Rates.—Section 1886(m)(6)(B) of the Social Security Act (42 U.S.C. 1395ww(m)(6)(B)) is amended—
(1) in clause (ii), in the matter preceding sub-
clause (I), by striking “In this paragraph” and in-
serting “Subject to clause (iv), in this paragraph”;
and

(2) by adding at the end the following new
clause:

“(iv) Adjustment.—For each of fis-
cal years 2018 through 2026, the amount
that would otherwise apply under clause
(ii)(I) for the year (determined without re-
gard to this clause) shall be reduced by 4.6
percent.”.

SEC. 51006. RECOGNITION OF ATTENDING PHYSICIAN AS-
SISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) Recognition of Attending Physician As-
sistants as Attending Physicians to Serve Hos-
pice Patients.—

(1) In general.—Section 1861(dd)(3)(B) of
the Social Security Act (42 U.S.C. 1395x(dd)(3)(B))
is amended—

(A) by striking “or nurse” and inserting “,
the nurse”; and
(B) by inserting “, or the physician assistant (as defined in such subsection)” after “subsection (aa)(5))”.

(2) Clarification of hospice role of physician assistants.—Section 1814(a)(7)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting “or a physician assistant” after “a nurse practitioner”.

(b) Effective date.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2019.

SEC. 51007. EXTENSION OF ENFORCEMENT INSTRUCTION ON SUPERVISION REQUIREMENTS FOR OUT-PATIENT THERAPEUTIC SERVICES IN CRITICAL ACCESS AND SMALL RURAL HOSPITALS THROUGH 2017.

Section 1 of Public Law 113–198, as amended by section 1 of Public Law 114–112 and section 16004(a) of the 21st Century Cures Act (Public Law 114–255), is amended—

(1) in the section heading, by striking “2016” and inserting “2017”; and

(2) by striking “and 2016” and inserting “2016, and 2017”.
SEC. 51008. ALLOWING PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS TO SUPERVISE CARDIAC, INTENSIVE CARDIAC, AND PULMONARY REHABILITATION PROGRAMS.

(a) Cardiac and Intensive Cardiac Rehabilitation Programs.—Section 1861(eee) of the Social Security Act (42 U.S.C. 1395x(eee)) is amended—

(1) in paragraph (1)—

(A) by striking “physician-supervised”;

and

(B) by inserting “under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))” before the period at the end;

(2) in paragraph (2)—

(A) in subparagraph (A)(iii), by striking the period at the end and inserting a semicolon;

and

(B) in subparagraph (B), by striking “a physician” and inserting “a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse spe-
cialist (as those terms are defined in subsection (aa)(5))”; and

(3) in paragraph (4)(A), in the matter preceding clause (i)—

(A) by striking “physician-supervised”;

and

(B) by inserting “under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))” after “paragraph (3)”.

(b) PULMONARY REHABILITATION PROGRAMS.—Section 1861(fff)(1) of the Social Security Act (42 U.S.C. 1395x(fff)(1)) is amended—

(1) by striking “physician-supervised”; and

(2) by inserting “under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))” before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2024.
SEC. 51009. TRANSITIONAL PAYMENT RULES FOR CERTAIN RADIATION THERAPY SERVICES UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(11), by striking “2017 and 2018” and inserting “2017, 2018, and 2019”; and

(2) in subsection (c)(2)(K)(iv), by striking “2017 and 2018” and inserting “2017, 2018, and 2019”.

TITLE XI—PROTECTING SENIORS’ ACCESS TO MEDICARE ACT

SEC. 52001. REPEAL OF THE INDEPENDENT PAYMENT ADVISORY BOARD.

(a) REPEAL.—Section 1899A of the Social Security Act (42 U.S.C. 1395kkk) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) LOBBYING COOLING-OFF PERIOD.—Paragraph (3) of section 207(e) of title 18, United States Code, is repealed.

(2) GAO STUDY AND REPORT.—Section 3403(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395kkk–1) is repealed.
(3) MedPAC review and comment.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

(A) by striking paragraph (4);

(B) by redesignating paragraphs (5) through (8) as paragraphs (4) through (7), respectively; and

(C) by redesignating the paragraph (9) that was redesignated by section 3403(c)(1) of the Patient Protection and Affordable Care Act (Public Law 111–148) as paragraph (8).

(4) Name change.—Section 10320(b) of the Patient Protection and Affordable Care Act (Public Law 111–148) is repealed.

(5) Rule of construction.—Section 10320(e) of the Patient Protection and Affordable Care Act (Public Law 111–148) is repealed.

**TITLE XII—OFFSETS**

**SEC. 53101. MODIFYING REDUCTIONS IN MEDICAID DSH ALLOTMENTS.**

Section 1923(f)(7)(A) of the Social Security Act (42 U.S.C. 1396r–4(f)(7)(A)) is amended—

(1) in clause (i), in the matter preceding subclause (I), by striking “2018” and inserting “2020”;

and
(2) in clause (ii), by striking subclauses (I) through (VIII) and inserting the following:

“(I) $4,000,000,000 for fiscal year 2020; and
“(II) $8,000,000,000 for each of fiscal years 2021 through 2025.”.

SEC. 53102. THIRD PARTY LIABILITY IN MEDICAID AND CHIP.

(a) Modification of Third Party Liability Rules Related to Special Treatment of Certain Types of Care and Payments.—

(1) In general.—Section 1902(a)(25)(E) of the Social Security Act (42 U.S.C. 1396a(a)(25)(E)) is amended, in the matter preceding clause (i), by striking “prenatal or”.

(2) Effective date.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

(b) Delay in Effective Date and Repeal of Certain Bipartisan Budget Act of 2013 Amendments.—

(1) Repeal.—Effective as of September 30, 2017, subsection (b) of section 202 of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note) (including any amend-
ments made by such subsection) is repealed and the provisions amended by such subsection shall be applied and administered as if such amendments had never been enacted.

(2) Delay in Effective Date.—Subsection (c) of section 202 of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note) is amended to read as follows:

“(c) Effective Date.—The amendments made by subsection (a) shall take effect on October 1, 2019.”

(3) Effective Date; Treatment.—The repeal and amendment made by this subsection shall take effect as if enacted on September 30, 2017, and shall apply with respect to any open claims, including claims pending, generated, or filed, after such date. The amendments made by subsections (a) and (b) of section 202 of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note) that took effect on October 1, 2017, are null and void and section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) shall be applied and administered as if such amendments had not taken effect on such date.

(c) GAO Study and Report.—Not later than 18 months after the date of enactment of this Act, the Comp-
troller General of the United States shall submit a report to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the impacts of the amendments made by subsections (a)(1) and (b)(2), including—

(1) the impact, or potential effect, of such amendments on access to prenatal and preventive pediatric care (including early and periodic screening, diagnostic, and treatment services) covered under State plans under such title (or waivers of such plans);

(2) the impact, or potential effect, of such amendments on access to services covered under such plans or waivers for individuals on whose behalf child support enforcement is being carried out by a State agency under part D of title IV of such Act; and

(3) the impact, or potential effect, on providers of services under such plans or waivers of delays in payment or related issues that result from such amendments.

(d) APPLICATION TO CHIP.—

(1) IN GENERAL.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—
(A) by redesignating subparagraphs (B) through (R) as subparagraphs (C) through (S), respectively; and 

(B) by inserting after subparagraph (A) the following new subparagraph:

“(B) Section 1902(a)(25) (relating to third party liability).”.

(2) MANDATORY REPORTING.—Section 1902(a)(25)(I)(i) of the Social Security Act (42 U.S.C. 1396a(a)(25)(I)(i)) is amended—

(A) by striking “medical assistance under the State plan” and inserting “medical assistance under a State plan (or under a waiver of the plan)”;

(B) by striking “(and, at State option, child” and inserting “and child”; and

(C) by striking “title XXI)” and inserting “title XXI”.

SEC. 53103. TREATMENT OF LOTTERY WINNINGS AND OTHER LUMP-SUM INCOME FOR PURPOSES OF INCOME ELIGIBILITY UNDER MEDICAID.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(17), by striking ““(e)(14),

(e)(14)” and inserting ““(e)(14), (e)(15)”; and
(2) in subsection (e)(14), by adding at the end the following new subparagraph:

“(K) Treatment of certain lottery winnings and income received as a lump sum.—

“(i) In general.—In the case of an individual who is the recipient of qualified lottery winnings (pursuant to lotteries occurring on or after January 1, 2018) or qualified lump sum income (received on or after such date) and whose eligibility for medical assistance is determined based on the application of modified adjusted gross income under subparagraph (A), a State shall, in determining such eligibility, include such winnings or income (as applicable) as income received—

“(I) in the month in which such winnings or income (as applicable) is received if the amount of such winnings or income is less than $80,000;

“(II) over a period of 2 months if the amount of such winnings or income (as applicable) is greater than or
equal to $80,000 but less than $90,000;

“(III) over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or equal to $90,000 but less than $100,000; and

“(IV) over a period of 3 months plus 1 additional month for each increment of $10,000 of such winnings or income (as applicable) received, not to exceed a period of 120 months (for winnings or income of $1,260,000 or more), if the amount of such winnings or income is greater than or equal to $100,000.

“(ii) Counting in equal installments.—For purposes of subclauses (II), (III), and (IV) of clause (i), winnings or income to which such subclause applies shall be counted in equal monthly installments over the period of months specified under such subclause.

“(iii) Hardship exemption.—An individual whose income, by application of
clause (i), exceeds the applicable eligibility threshold established by the State, shall continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility of the individual would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary.

“(iv) NOTIFICATIONS AND ASSISTANCE REQUIRED IN CASE OF LOSS OF ELIGIBILITY.—A State shall, with respect to an individual who loses eligibility for medical assistance under the State plan (or a waiver of such plan) by reason of clause (i)—

“(I) before the date on which the individual loses such eligibility, inform the individual—

“(aa) of the individual’s opportunity to enroll in a qualified health plan offered through an Exchange established under title
I of the Patient Protection and Affordable Care Act during the special enrollment period specified in section 9801(f)(3) of the Internal Revenue Code of 1986 (relating to loss of Medicaid or CHIP coverage); and

“(bb) of the date on which the individual would no longer be considered ineligible by reason of clause (i) to receive medical assistance under the State plan or under any waiver of such plan and be eligible to reapply to receive such medical assistance; and

“(II) provide technical assistance to the individual seeking to enroll in such a qualified health plan.

“(v) QUALIFIED LOTTERY WINNINGS DEFINED.—In this subparagraph, the term ‘qualified lottery winnings’ means winnings from a sweepstakes, lottery, or pool described in paragraph (3) of section 4402 of the Internal Revenue Code of 1986 or a
lottery operated by a multistate or multijurisdictional lottery association, including amounts awarded as a lump sum payment.

“(vi) QUALIFIED LUMP SUM INCOME DEFINED.—In this subparagraph, the term ‘qualified lump sum income’ means income that is received as a lump sum from monetary winnings from gambling (as defined by the Secretary and including gambling activities described in section 1955(b)(4) of title 18, United States Code).”.

(b) RULES OF CONSTRUCTION.—

(1) INTERCEPTION OF LOTTERY WINNINGS ALLOWED.—Nothing in the amendment made by subsection (a)(2) shall be construed as preventing a State from intercepting the State lottery winnings awarded to an individual in the State to recover amounts paid by the State under the State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for medical assistance furnished to the individual.

(2) APPLICABILITY LIMITED TO ELIGIBILITY OF RECIPIENT OF LOTTERY WINNINGS OR LUMP SUM INCOME.—Nothing in the amendment made by subsection (a)(2) shall be construed, with respect to a
determination of household income for purposes of a
determination of eligibility for medical assistance
under the State plan under title XIX of the Social
Security Act (42 U.S.C. 1396 et seq.) (or a waiver
of such plan) made by applying modified adjusted
gross income under subparagraph (A) of section
1902(e)(14) of such Act (42 U.S.C. 1396a(e)(14)),
as limiting the eligibility for such medical assistance
of any individual that is a member of the household
other than the individual who received qualified lot-
tery winnings or qualified lump-sum income (as de-
finite in subparagraph (K) of such section
1902(e)(14), as added by subsection (a)(2) of this
section).

SEC. 53104. REBATE OBLIGATION WITH RESPECT TO LINE
EXTENSION DRUGS.

(a) In General.—Section 1927(c)(2)(C) of the So-
cial Security Act (42 U.S.C. 1396r–8(c)(2)(C)) is amend-
ed by striking “(C) TREATMENT OF NEW FORMULA-
TIONS.—In the case” and all that follows through the pe-
period at the end of the first sentence and inserting the fol-
lowing:

“(C) TREATMENT OF NEW FORMULA-
TIONS.—
“(i) IN GENERAL.—In the case of a
drug that is a line extension of a single
source drug or an innovator multiple
source drug that is an oral solid dosage
form, the rebate obligation for a rebate pe-
riod with respect to such drug under this
subsection shall be the greater of the
amount described in clause (ii) for such
drug or the amount described in clause
(iii) for such drug.

“(ii) AMOUNT 1.—For purposes of
clause (i), the amount described in this
clause with respect to a drug described in
clause (i) and rebate period is the amount
computed under paragraph (1) for such
drug, increased by the amount computed
under subparagraph (A) and, as applicable,
subparagraph (B) for such drug and re-
bate period.

“(iii) AMOUNT 2.—For purposes of
clause (i), the amount described in this
clause with respect to a drug described in
clause (i) and rebate period is the amount
computed under paragraph (1) for such
drug, increased by the product of—
“(I) the average manufacturer price for the rebate period of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;

“(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this paragraph for the rebate period for any strength of the original single source drug or innovator multiple source drug; and

“(III) the total number of units of each dosage form and strength of the line extension product paid for under the State plan in the rebate period (as reported by the State).”.

(b) EFFECTIVE DATE.—The amendments made subsection (a) shall apply with respect to rebate periods beginning on or after October 1, 2018.

SEC. 53105. MEDICAID IMPROVEMENT FUND.

Section 1941(b) of the Social Security Act (42 U.S.C. 1396w–1(b)) is amended—

(1) in paragraph (1), by striking “$5,000,000” and inserting “$0”; and
SEC. 53106. PHYSICIAN FEE SCHEDULE UPDATE.

Section 1848(d)(18) of the Social Security Act (42 U.S.C. 1395w–4(d)(18)) is amended by striking “paragraph (1)(C)” and all that follows and inserting the following: “paragraph (1)(C)—

“(A) for 2016 and each subsequent year through 2018 shall be 0.5 percent; and

“(B) for 2019 shall be 0.25 percent.”.

SEC. 53107. PAYMENT FOR OUTPATIENT PHYSICAL THERAPY SERVICES AND OUTPATIENT OCCUPATIONAL THERAPY SERVICES FURNISHED BY A THERAPY ASSISTANT.

Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(v) Payment for Outpatient Physical Therapy Services and Outpatient Occupational Therapy Services Furnished by a Therapy Assistant.—

“(1) In general.—In the case of an outpatient physical therapy service or outpatient occupational therapy service furnished on or after January 1, 2022, for which payment is made under section 1848 or subsection (k), that is furnished in
whole or in part by a therapy assistant (as defined by the Secretary), the amount of payment for such service shall be an amount equal to 85 percent of the amount of payment otherwise applicable for the service under this part. Nothing in the preceding sentence shall be construed to change applicable requirements with respect to such services.

“(2) USE OF MODIFIER.—

“(A) ESTABLISHMENT.—Not later than January 1, 2019, the Secretary shall establish a modifier to indicate (in a form and manner specified by the Secretary), in the case of an outpatient physical therapy service or outpatient occupational therapy service furnished in whole or in part by a therapy assistant (as so defined), that the service was furnished by a therapy assistant.

“(B) REQUIRED USE.—Each request for payment, or bill submitted, for an outpatient physical therapy service or outpatient occupational therapy service furnished in whole or in part by a therapy assistant (as so defined) on or after January 1, 2020, shall include the modifier established under subparagraph (A) for each such service.
“(3) IMPLEMENTATION.—The Secretary shall implement this subsection through notice and comment rulemaking.”.

SEC. 53108. REDUCTION FOR NON-EMERGENCY ESRD AMBULANCE TRANSPORTS.

Section 1834(l)(15) of the Social Security Act (42 U.S.C. 1395m(l)(15)) is amended by striking “on or after October 1, 2013” and inserting “during the period beginning on October 1, 2013, and ending on September 30, 2018, and by 23 percent for such services furnished on or after October 1, 2018”.

SEC. 53109. HOSPITAL TRANSFER POLICY FOR EARLY DISCHARGES TO HOSPICE CARE.

(a) IN GENERAL.—Section 1886(d)(5)(J) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(J)) is amended—

(1) in clause (ii)—

(A) in subclause (III), by striking “or” at the end;

(B) by redesignating subclause (IV) as subclause (V); and

(C) by inserting after subclause (III) the following new subclause:
“(IV) for discharges occurring on or after October 1, 2018, is provided hospice care by a hospice program; or”; and

(2) in clause (iv)—

(A) by inserting after the first sentence the following new sentence: “The Secretary shall include in the proposed rule published for fiscal year 2019, a description of the effect of clause (ii)(IV).”; and

(B) in subclause (I), by striking “and (III)” and inserting “(III), and, in the case of proposed and final rules for fiscal year 2019 and subsequent fiscal years, (IV)”."

(b) **MEDPAC EVALUATION AND REPORT.**—

(1) **EVALUATION.**—The Medicare Payment Advisory Commission (in this subsection referred to as the “Commission”) shall conduct an evaluation of the effects of the amendments made by subsection (a), including the effects on—

(A) the numbers of discharges of patients from an inpatient hospital setting to a hospice program;

(B) the lengths of stays of patients in an inpatient hospital setting who are discharged to a hospice program;
(C) spending under the Medicare program under title XVIII of the Social Security Act; and

(D) other areas determined appropriate by the Commission.

(2) CONSIDERATION.—In conducting the evaluation under paragraph (1), the Commission shall consider factors such as whether the timely access to hospice care by patients admitted to a hospital has been affected through changes to hospital policies or behaviors made as a result of such amendments.

(3) PRELIMINARY RESULTS.—Not later than March 15, 2020, the Commission shall provide Congress with preliminary results on the evaluation being conducted under paragraph (1).

(4) REPORT.—Not later than March 15, 2021, the Commission shall submit to Congress a report on the evaluation conducted under paragraph (1).

SEC. 53110. MEDICARE PAYMENT UPDATE FOR HOME HEALTH SERVICES.

Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (iii), in the last sentence, by inserting before the period at the end the following: “and for 2020 shall be 1.5 percent”; and
(2) in clause (vi), by inserting “and 2020” after “except 2018”.

SEC. 53111. MEDICARE PAYMENT UPDATE FOR SKILLED NURSING FACILITIES.

Section 1888(e)(5)(B) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(B)) is amended—

(1) in clause (i), by striking “and (iii)” and inserting “, (iii), and (iv)”;

(2) in clause (ii), by striking “clause (iii)” and inserting “clauses (iii) and (iv)”;

(3) by adding at the end the following new clause:

“(iv) SPECIAL RULE FOR FISCAL YEAR 2019.—For fiscal year 2019 (or other similar annual period specified in clause (i)), the skilled nursing facility market basket percentage, after application of clause (ii), is equal to 2.4 percent.”.

SEC. 53112. PREVENTING THE ARTIFICIAL INFLATION OF STAR RATINGS AFTER THE CONSOLIDATION OF MEDICARE ADVANTAGE PLANS OFFERED BY THE SAME ORGANIZATION.

Section 1853(o)(4) of the Social Security Act (42 U.S.C. 1395w–23(o)(4)) is amended by adding at the end the following new subparagraph:
“(D) Special rule to prevent the artificial inflation of star ratings after the consolidation of Medicare Advantage plans offered by a single organization.—

“(i) In general.—If—

“(I) a Medicare Advantage organization has entered into more than one contract with the Secretary with respect to the offering of Medicare Advantage plans; and

“(II) on or after January 1, 2019, the Secretary approves a request from the organization to consolidate the plans under one or more contract (in this subparagraph referred to as a ‘closed contract’) with the plans offered under a separate contract (in this subparagraph referred to as the ‘continuing contract’); with respect to the continuing contract, the Secretary shall adjust the quality rating under the 5-star rating system and any quality increase under this subsection and rebate amounts under section 1854 to re-
fleets an enrollment-weighted average of
scores or ratings for the continuing and
closed contracts, as determined appropriate
by the Secretary.

“(ii) APPLICATION.—An adjustment
under clause (i) shall apply for any year
for which the quality rating of the con-
tinuing contract is based primarily on a
measurement period that is prior to the
first year in which a closed contract is no
longer offered.”.

SEC. 53113. SUNSETTING EXCLUSION OF BIOSIMILARS
FROM MEDICARE PART D COVERAGE GAP
DISCOUNT PROGRAM.

Section 1860D–14A(g)(2)(A) of the Social Security
Act (42 U.S.C. 1395w–114a(g)(2)(A)) is amended by in-
serting “, with respect to a plan year before 2019,” after
“other than”.

SEC. 53114. ADJUSTMENTS TO MEDICARE PART B AND
PART D PREMIUM SUBSIDIES FOR HIGHER
INCOME INDIVIDUALS.

(a) IN GENERAL.—Section 1839(i)(3)(C)(i) of the
Social Security Act (42 U.S.C. 1395r(i)(3)(C)(i)) is
amended—
(1) in subclause (II), in the matter preceding the table, by striking “years beginning with”; and

(2) by adding at the end the following new subclause:

“(III) Subject to paragraph (5), for years beginning with 2019:

"If the modified adjusted gross income is: .... The applicable percentage is:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than $85,000 but not more than $107,000</td>
<td>35 percent</td>
</tr>
<tr>
<td>More than $107,000 but not more than $133,500</td>
<td>50 percent</td>
</tr>
<tr>
<td>More than $133,500 but not more than $160,000</td>
<td>65 percent</td>
</tr>
<tr>
<td>More than $160,000 but less than $500,000</td>
<td>80 percent</td>
</tr>
<tr>
<td>At least $500,000</td>
<td>85 percent.</td>
</tr>
</tbody>
</table>

(b) JOINT RETURNS.—Section 1839(i)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395r(i)(3)(C)(ii)) is amended by inserting before the period the following: “except, with respect to the dollar amounts applied in the last row of the table under subclause (III) of such clause (and the second dollar amount specified in the second to last row of such table), clause (i) shall be applied by substituting dollar amounts which are 150 percent of such dollar amounts for the calendar year”.

(e) INFLATION ADJUSTMENT.—Section 1839(i)(5) of the Social Security Act (42 U.S.C. 1395r(i)(5)) is amend—

(1) in subparagraph (A), by striking “In the case” and inserting “Subject to subparagraph (C), in the case”;


(2) in subparagraph (B), by striking “subpara-
graph (A)” and inserting “subparagraph (A) or
(C)” ; and

(3) by adding at the end the following new sub-
paragraph:

“(C) Treatment of Adjustments for
Certain Higher Income Individuals.—

“(i) In general.—Subparagraph (A)
shall not apply with respect to each dollar
amount in paragraph (3) of $500,000.

“(ii) Adjustment beginning 2028.—
In the case of any calendar year beginning
after 2027, each dollar amount in para-
graph (3) of $500,000 shall be increased
by an amount equal to—

“(I) such dollar amount, multi-
plied by

“(II) the percentage (if any) by
which the average of the Consumer
Price Index for all urban consumers
(United States city average) for the
12-month period ending with August
of the preceding calendar year exceeds
such average for the 12-month period
ending with August 2026.”. 
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1 SEC. 53115. MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42
U.S.C. 1395iii(b)(1)) is amended by striking
“$220,000,000” and inserting “$0”.

SEC. 53116. CLOSING THE DONUT HOLE FOR SENIORS.

(a) CLOSING DONUT HOLE SOONER.—Section
1860D–2(b)(2)(D) of the Social Security Act (42 U.S.C.
1395w–102(b)(2)(D))—

(1) in clause (i), by amending subclause (I) to
read as follows:

“(I) equal to the difference be-
 tween—

“(aa) the applicable gap per-
centage (specified in clause (ii)
for the year); and

“(bb) the discount percent-
age specified in section 1860D–
14A(g)(4)(A) for such applicable
drugs (or, in the case of a year
after 2018, 50 percent); or”; and

(2) in clause (ii)—

(A) in subclause (IV), by adding “and” at
the end;

(B) by striking subclause (V); and

(C) in subclause (VI)—
SEC. 53117. MODERNIZING CHILD SUPPORT ENFORCEMENT FEES.

(a) In General.—Section 454(6)(B)(ii) of the Social Security Act (42 U.S.C. 654(6)(B)(ii)) is amended—

(1) by striking “$25” and inserting “$35”; and

(2) by striking “$500” each place it appears and inserting “$550”.

(b) Effective Date.—

(1) In General.—The amendments made by subsection (a) shall take effect on the 1st day of the 1st fiscal year that begins on or after the date of the enactment of this Act, and shall apply to payments under part D of title IV of the Social Security Act (42 U.S.C. 651 et seq.) for calendar quarters beginning on or after such 1st day.
(2) Delay permitted if state legislation required.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan developed pursuant to part D of title IV of the Social Security Act (42 U.S.C. 651 et seq.) to meet the requirements imposed by the amendment made by subsection (a), the plan shall not be regarded as failing to meet such requirements before the 1st day of the 1st calendar quarter beginning after the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the preceding sentence, if the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature.

SEC. 53118. INCREASING EFFICIENCY OF PRISON DATA REPORTING.

(a) In General.—Section 1611(e)(1)(I)(i)(II) of the Social Security Act (42 U.S.C. 1382(e)(1)(I)(i)(II)) is amended by striking “30 days” each place it appears and inserting “15 days”.

(b) Effective Date.—The amendments made by subsection (a) shall apply with respect to any payment made by the Commissioner of Social Security pursuant to
section 1611(e)(1)(I)(i)(II) of the Social Security Act (42 U.S.C. 1382(e)(1)(I)(i)(II)) (as amended by such subsection) on or after the date that is 6 months after the date of enactment of this Act.

SEC. 53119. PREVENTION AND PUBLIC HEALTH FUND.

Section 4002(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 300u-11(b)), as amended by section 3103 of Public Law 115-96, is amended by striking paragraphs (4) through (9) and inserting the following:

“(4) for fiscal year 2019, $900,000,000;

“(5) for each of fiscal years 2020 and 2021, $950,000,000;

“(6) for each of fiscal years 2022 and 2023, $1,000,000,000;

“(7) for each of fiscal years 2024, 2025, 2026, and 2027, $1,475,000,000; and

“(8) for fiscal year 2028 and each fiscal year thereafter, $2,000,000,000.”.