U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

October 2, 2017

TO: Members, Full Committee

FROM: Committee Majority Staff

RE: Full Committee Markup

I. INTRODUCTION

The Full Committee will meet in open markup session on October 4, 2017, in 2123 Rayburn House Office Building.

On October 4, 2017, at 1:00 p.m. the Full Committee convene to consider the following:

- H.R. __, The Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable (HEALTHY KIDS) Act of 2017, authored by Rep. Burgess.
- H.R. __, The Community Health And Medical Professionals Improve Our Nation (CHAMPION) Act, authored by Rep. Walden.
- H.R. 849, The Protecting Seniors' Access to Medicare Act of 2017, authored by Rep. Phil Roe (R-TN) and Ruiz.
- H.R. 1148, The Furthering Access to Stroke Telemedicine Act of 2017, authored by Rep. Morgan Griffith (R-VA) and Rep. Joyce Beatty (D-OH).
- H.R. 2465, The Steve Gleason Enduring Voices Act of 2017, authored by House Republican Conference Chair Rep. Cathy McMorris Rogers (R-WA), House Majority Whip Rep. Steve Scalise (R-LA), and Rep. John Larson (D-CT).
- H.R. 2557, The Prostate Cancer Misdiagnosis Elimination Act of 2017, authored by Rep. Larry Bucshon (R-IN) and Rep. Bobby Rush (D-IL).
- H.R. 3120, to reduce the volume of future electronic health record-related significant hardship requests, authored by Chairman Burgess and Rep. Debbie Dingell (D-MI).
- H.R. 3245, The Medicare Civil and Criminal Penalties Act, authored by Rep. Gus Bilirakis (R-FL) and Rep. Kathy Castor (D-FL).
- H.R. 3263, to extend the Medicare Independence at home Medical Practice Demonstration program, authored by Chairman Burgess and Rep. Dingell.

- H.R. 3271, The Protecting Access to Diabetes Supplies Act of 2017, authored by Rep. Diana DeGette (D-CO) and Rep. Susan Brooks (R-IN).

In keeping with Chairman Walden's announced policy, Members must submit any amendments they may have two hours before they are offered during this markup. Members may submit amendments by email to peter.kielty@mail.house.gov. Any information with respect to an amendment's parliamentary standing (e.g., its germaneness) should be submitted at this time as well.

II. EXPLANATION OF LEGISLATION

A. H.R. XXX, The Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable (HEALTHY KIDS) Act of 2017.

Title I

CHIP Current Law

The Children's Health Insurance Program (CHIP) is a means-tested program that provides health coverage to targeted low-income children and pregnant women in families that have annual income above Medicaid eligibility levels but have no health insurance. CHIP is jointly financed by the federal government and states, and the states are responsible for administering CHIP. In FY 2015, 8.4 million children received CHIP-funded coverage. Spending for FY 2015 totaled $13.7 billion ($9.7 billion federal, $4.0 billion state). CHIP spending is reimbursed by the federal government at a matching rate higher than Medicaid's. CHIP's enhanced federal medical assistance percentage (E-FMAP) varies by state, historically ranging from 65 percent to 81 percent, compared to 50 percent to 73 percent for children in Medicaid. Federal CHIP allotments are provided to states annually, with amounts based on each state's recent CHIP spending increased by a growth factor. States have two years to spend each allotment, with unspent funds available for redistribution to other states. In addition to redistribution funds, federal CHIP contingency funds are available to qualifying states that exhaust their CHIP allotments. (Unlike Medicaid, federal CHIP funding is capped. States may exhaust all federal CHIP funding, although this has not occurred since the enactment of the current allotment structure in the *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA).

Under the SCHIP program, the federal government sets basic requirements for SCHIP, but states have the flexibility to design their version of SCHIP within the federal government's basic framework. As a result, there is significant variation across SCHIP programs. Currently, state upper-income eligibility limits for children range from a low of 175 percent of the federal poverty level (FPL) to a high of 405 percent of FPL. States may also extend SCHIP coverage to pregnant women when certain conditions are met. While individuals who meet Medicaid program criteria (including the criteria for Medicaid-expansion SCHIP programs) are entitled to Medicaid coverage, there is no individual entitlement to coverage in separate SCHIP programs. Similarly, funding is not open-ended.

Overall, 8.4 million children were enrolled in CHIP-funded coverage at any point during FY 2015. About 40 percent (3.4 million) were children age 0–18 in separate CHIP programs, 56 percent (4.7 million) were children in Medicaid-expansion CHIP programs, and just under 4 percent (0.3 million) were unborn children in separate CHIP programs. States may also provide CHIP-funded coverage to pregnant women. In FY 2015, states electing this option covered 4,200 pregnant women.

Section 2101 of the Affordable Care Act increased the SCHIP E-FMAP by 23 percent, from October 1, 2016, through September 30, 2019. Therefore, under current law, for fiscal years through 2019, the SCHIP matching rate ranges from 88 percent to 100 percent. In FY 2017, 12 states have E-FMAPs at 100 percent. However, the ACA did not include additional or extended funding for SCHIP, so Congress had to extend funding in MACRA. The ACA also required states to maintain income eligibility levels for SCHIP through September 30, 2019, as a condition for receiving payments under Medicaid (notwithstanding the lack of corresponding federal appropriations for FY 2018 and FY 2019). This provision is often referred to as the "Maintenance of Effort" (MOE) requirement.

Federal funding for CHIP expired September 30, 2017. States are currently using unspent FY2017 CHIP allotments and redistributed funds from the Centers for Medicare and Medicaid Services (CMS) to cover current spending needs for their CHIP programs. Without Congressional action, states could start to exhaust these funds as early as November. Additionally, if CHIP funding were not extended soon, states will need to take steps to notify CHIP children and families of possible changes in health coverage. As the National Association of State Medicaid Directors (NAMD) said in a September 13, 2017 letter to Congressional Committee leadership, "state laws, regulations, and policies require that states issue notice to beneficiaries of coverage changes or terminations well in advance of these changes occurring."[1] NAMD also noted that "states must develop plans on how to direct children and families currently receiving CHIP coverage, should they need to freeze or close their program." Most children currently enrolled in CHIP would be eligible for health coverage in Medicaid, the Exchanges, or employer-sponsored coverage, but not all children would necessarily be insured, and those coverage sources vary widely regarding an individual's cost-sharing, children's pediatric provider networks, and other important factors.

CHIP Policy Proposal

This legislation provides five years of federal appropriations for CHIP, for FY2018 through FY2022. The funding levels and matching rates mirror the same policies and provisions including the bipartisan Senate bill, S. 1287, The *Keep Kids' Insurance Dependable and Secure* (KIDS) Act of 2017.[2] This bill restores the historically successful federal-state partnership by not extending the 23 percent E-FMAP created in Obamacare beyond its current expiration at the end of FY2019. Mirroring S.1287, this legislation does include a 11.5 percent increased match in FY2020 before returning to the regular CHIP matching rates in FY2021 and FY2022.

[1] http://medicaiddirectors.org/wp-content/uploads/2017/09/NAMD-CHIP-funding-letter-to-Congress-9-13-16.pdf
[2] https://www.congress.gov/bill/115th-congress/senate-bill/1827/text

This language also extends the CHIP MOE requirements for children in families with annual income less than 300% of the federal poverty level for three years from October 1, 2019, through September 30, 2022. The language extends Express Lane Eligibility, the Qualifying State Option and the Child Contingency Fund for five years. Finally, this language includes five years of funding for the following programs at levels specified under current law: the Childhood Obesity Demonstration Project; the Pediatric Quality Measures Program; and Outreach and Enrollment Grants.

Puerto Rico Medicaid Current Law

Under current law, the federal government and the government of Puerto Rico jointly finance Puerto Rico's Medicaid program. Puerto Rico must contribute its non-federal share of Medicaid spending in order to access federal dollars, which are matched at the designated federal medical assistance percentage (FMAP), or matching rate. Unlike the states, for which federal Medicaid spending is open-ended, Puerto Rico can access federal dollars only up to an annual ceiling.

Federal Medicaid spending in Puerto Rico is subject to an annual funding ceiling specified in statute, which grows with the medical component of the Consumer Price Index for Urban Consumers (CPI-U) (§1108(g)). Puerto Rico's CHIP allotment is determined by the Centers for Medicare & Medicaid Services (CMS) based on prior year spending, the same methodology used for states. In fiscal year (FY) 2015, federal funding for Medicaid was $329 million and federal funding for CHIP was $183 million (MACPAC 2016). In general, once Puerto Rico exhausts its annual Medicaid and CHIP ceilings, it must fund its program with territory funds. However, Section 2005 of the ACA provided the territories with $6.3 billion in additional federal funds for their Medicaid programs. Section 2005 funds for Puerto Rico totaled $5.4 billion, which are available to be drawn down between July 2011 and September 2019 (CMS 2016a).5 The Consolidated Appropriations Act of 2017 (P.L. 115-31) provided Puerto Rico with an additional $295.9 million. Puerto Rico must contribute a non-federal share to access these funds, which is matched at its FMAP rate (CMS 2016a). After these funds expire or are exhausted, Puerto Rico will generally not be able to spend federal dollars beyond the ceiling for Medicaid. According to MACPAC, Puerto Rico is projected to exhaust remaining funds ($331.6 million) by April 2018 and will face up to an $877 million shortfall in funding.[3]

Puerto Rico Medicaid Policy Proposal

The legislation would make available from October 1, 2017, through December 31, 2019, $880 million for Puerto Rico's Medicaid program. It would also make an additional $120 million available for that period if the Financial Oversight and Management Board for Puerto Rico certifies by a majority vote that the Puerto Rico Medicaid program has taken reasonable and appropriate steps to:

- reduce Medicaid fraud, waste, and abuse;
- implement strategies to reduce unnecessary, inefficient or excessive Medicaid spending;
- improve the use and availability of Medicaid data for program operation and oversight;

[3] https://www.macpac.gov/wp-content/uploads/2017/09/Medicaid-Financing-and-Spending-in-Puerto-Rico.pdf

- improve the quality of care and patient experience for Medicaid enrollees.

The legislation would also provide a temporary increase in the growth rate of the annual funding ceiling and provide a 90% federal matching rate for both state expenditures related to the operation of a state Medicaid fraud control unit and for costs attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel. Finally, the legislation also requires additional reporting to the Financial Oversight and Management Board for Puerto Rico**.**

Medicaid DSH Allotments Current Law

The Medicaid statute requires states to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients. The federal government provides each state an annual DSH allotment, which is the maximum amount of federal matching funds that each state can claim for Medicaid DSH payments. The ACA included a provision directing the Secretary to make aggregate reductions in Medicaid DSH allotments in specified annual amounts for FY2014 through FY2020. Since the ACA, a number of laws have amended the ACA Medicaid DSH reductions by eliminating the reductions for FY2014 through FY2016, changing the reduction amounts, and extending the reductions through FY2024. MACRA followed suit by eliminating the FY2017 reductions and extending the reductions to FY2025. Section 412 of MACRA amended the Medicaid DSH reductions by pushing the Medicaid DSH reductions out one year (i.e., eliminating the FY2017 reductions and extending the reductions to FY2025) and increasing the aggregate reduction amounts from $35.1 billion to $43.0 billion.

Medicaid DSH Allotments Policy Proposal

The legislation would eliminate $2 billion in reductions for DSH allotments for FY2018 and offset the cost of the policy by extending DSH reductions through FY2026 and FY2027.

Title II

Unlike the Senate KIDS Act, the House HEALTHY KIDS Act also includes offset policies designed to appropriately reduce federal spending so the extension of CHIP funding does not increase the deficit.

Medicaid Third Party Liability Reform

Under current law, Medicaid is designated as the payer of last resort. This means that if a Medicaid beneficiary receives supplemental coverage through an additional payer, that payer must cover any claims that it is liable for, before Medicaid covers any additional claims. This holds true whether this third-party payer is Medicare, a private insurer, or any other payer. So if Medicaid beneficiaries have another source of payment for health services or items covered by Medicaid, that source should pay before Medicaid does, up to the extent of its liability. These other sources of payment are referred to as third parties.

Previous work by the Government Accountability Office (GAO) and Health and Human Services Office of the Inspector General (HHS OIG) has found millions of Medicaid beneficiaries have additional health insurance through third-party sources. According to work by GAO and HHS OIG, it is common for Medicaid beneficiaries to have one or more additional sources of coverage for health care services.[4] A January 2015 GAO report estimated that in 2012, 7.6 million Medicaid enrollees (13.4 percent) had private health insurance.[5] A January 2013 HHS OIG report found that "from 2008 to 2010, an estimated 15 percent (approximately 6.8 million) of Medicaid beneficiaries had employer-sponsored health insurance annually" – and the number is likely even higher when other sources of coverage are considered.[6] GAO also noted that the number of Medicaid enrollees with private health insurance has increased with the expansion of Medicaid under PPACA. Using a projection from 2012 Census data, GAO estimated that "about 868,000 of the projected 7 million new enrollees in 2014 would be expected to have private insurance."

Today, CMS requires states to provide for the identification of Medicaid enrollees' other sources of health coverage, verification of the extent of the other sources' liability for services, avoidance of payment for services in most circumstances where the state believes a third party is liable, and recovery of reimbursement from liable third parties after Medicaid payment, if the state can reasonably expect to recover more than it spends in seeking reimbursement.[7] States must ask beneficiaries at the time of their initial applications for and redeterminations of Medicaid eligibility whether they have other sources of health coverage. In addition, States must independently identify health coverage of Medicaid beneficiaries by matching States' coverage files with those of third parties. States must also conduct diagnosis and trauma edits on Medicaid claims to identify potential casualty and liability coverage.

Although current law requires for these third-party payers to cover these claims, work by GAO and HHS OIG have demonstrated there is additional savings to the Medicaid program by adopting reforms to improve the process so the Medicaid program only pays for Medicaid claims. For example, today, states are legally prohibited from using cost avoidance strategies in some cases. The Social Security Act requires that States pay and chase claims instead of using cost avoidance when (1) the service is prenatal care; (2) the service is preventive pediatric care, or (3) coverage is through a parent whose obligation to pay support is enforced by the States' child enforcement agency. Cost avoidance occurs when states do not pay providers for services until any other coverage has paid to the extent of its liability, rather than paying up front and recovering costs later. After a state has verified other coverage, it must generally seek to ensure that health care providers' claims are directed to the responsible party. When States recognize claims as belonging to beneficiaries who have other insurance, they will deny payment and return the claims to providers, who are then required to bill and collect payment from any liable third parties. If States have electronic claims processing systems, they can automatically deny payment when claims enter their systems.

---

[4] https://oig.hhs.gov/oei/reports/oei-05-11-00130.pdf and https://www.gao.gov/assets/670/668134.pdf
[5] GAO-15-208 *Medicaid Third-Party Liability*, https://www.gao.gov/assets/670/668134.pdf
[6] https://oig.hhs.gov/oei/reports/oei-05-11-00130.pdf
[7] A summary of current statutory requirements is available at CMS's website at: https://www.medicaid.gov/medicaid/eligibility/downloads/summaryoffederalstatutoryrequirements.pdf

States' reported cost-avoidance savings accounted for most TPL growth and total savings between 2001 and 2011. States' reported savings from cost avoidance grew 117 percent, from $33 billion to $70 billion, between 2001 and 2011. Cumulatively, States reported that they avoided paying $512 billion from 2001 to 2011.

If states were allowed to use cost avoidance strategies more broadly, they could save billions of dollars. HHS OIG has found "cost avoidance is the most cost-effective way to ensure that Medicaid is the payer of last resort. When States avoid costs, they do not pay money upfront or spend resources on recovery. Once States deny payment and notify providers of a liable third party, providers should bill future claims to the third party first, rather than the States."[8] As GAO has said, it is "the cost-avoidance process accounts for the bulk of the cost savings associated with third-party liability."[9]

President Obama's FY2013 Budget proposed to change this outdated barrier in federal law. The FY2013 Budget proposal allowed states to avoid costs for prenatal and preventive pediatric claims when third parties are responsible, allowed states to collect medical child support where health insurance is available from a non-custodial parent, and allowed Medicaid to recover costs from beneficiary liability settlements.[10]

This legislation takes several steps to modernize and improve Medicaid third party liability. First, this legislation delays the provision from the Bipartisan Budget Act of 2013 related to Medicaid Amendments Relating to Beneficiary Liability Settlements from October 1, 2017 to October 1, 2019.[11] Second, effective October 1, 2019, the legislation also adopts the proposed improvements from President Obama's FY2013 Budget to close loopholes in the law have allowed for payers to avoid paying claims. Finally, the legislation would further:

- Consolidate and clarify third party liability terms used in the existing law;
- Clarify the division of labor between state governments and Medicaid managed care entities in carrying out third party liability functions; and
- Increase states' third party liability obligations, while also incentivizing states to make third party liability recoveries and penalizing states for failing to meet third party liability requirements.

Medicaid Lottery Winners

[8] https://oig.hhs.gov/oei/reports/oei-05-11-00130.pdf
[9] https://www.gao.gov/assets/670/668134.pdf
[10] HHS FY2013 Budget in Brief, page 63, accessible here: https://wayback.archive-it.org/3920/20140403203230/http://www.hhs.gov/budget/fy2013/budget-brief-fy2013.pdf
[11] The Bipartisan Budget Act of 2013 (BBA 13; P.L. 113-67, Division A), Section 202, "Strengthening Medicaid Third-Party Liability," amended the SSA to enable states to recover all portions of judgments received by Medicaid beneficiaries. In addition, Section 202 clarified that states may impose liens against Medicaid beneficiaries' property. These changes were scheduled to take effect October 1, 2014, but have proven very problematic for private sector third party settlements. As a result, PAMA Section 211 delayed the effective date of the beneficiary liability settlement amendment from October 1, 2014, until October 1, 2016. MACRA Section 220 further delayed the effective date for beneficiary liability settlements from October 1, 2016, until October 1, 2017.

Currently, individuals enrolled in Medicaid whose income is determined using Modified Adjusted Gross Income are not allowed to be disenrolled from Medicaid beyond the month in which they receive a large lump sum of income, such as lottery or gambling winnings. The legislation amends to specify how a state must treat qualified lottery winnings and lump sum income for purposes of determining an individual's income-based eligibility for a state Medicaid program. Specifically, a state shall include such winnings or income as income received: (1) in the month in which it was received, if the amount is less than $80,000; (2) over a period of two months, if the amount is at least $80,000 but less than $90,000; (3) over a period of three months, if the amount is at least $90,000 but less than $100,000; and (4) over an additional one-month period for each increment of $10,000 received, not to exceed 120 months. Qualified lump sum income includes: (1) monetary winnings from gambling; (2) damages received in lump sums or periodic payments, excluding monthly payments, on account of causes of action other than those arising from personal physical injuries or sickness; and (3) income received as liquid assets from the estate of a deceased individual.

An individual whose income exceeds the applicable eligibility threshold due to qualified lump-sum income shall continue to be eligible for medical assistance to the extent that the state determines that denial of eligibility would cause undue medical or financial hardship.
With respect to an individual who loses eligibility due to qualified lump-sum income, a state must provide specified notice and assistance related to the individual's potential enrollment in a qualified health plan under the Patient Protection and Affordable Care Act.

Income-Related Premiums in Medicare Parts B and D for Wealthy Seniors

Under current law, the portion of the Medicare Part B and Part D premium that a beneficiary pays is based on the beneficiary's income. Section 103 would increase the percentage that Medicare beneficiaries with modified adjusted gross income (MAGI) above $500,000 ($875,000 for a couple filing jointly) from 80 percent to 100 percent. Currently, beneficiaries that have incomes of $160,001 and above ($320,001 and above for a couple), subsequent to changes made in MACRA, pay 80 percent of their premium costs for Medicare Parts B & D.

The policy would keep those individuals making $160,001 - $500,000 (couples filing jointly below $875,000) in the same income relating bracket of 80% but create an additional 100% threshold for those above. Additionally, the language would index these higher amounts for inflation after 2027.

B. H.R. __, Community Health And Medical Professionals Improve Our Nation (CHAMPION) Act of 2017

H.R. __, Community Health And Medical Professionals Improve Our Nation Act of 2017, or CHAMPION Act, extends federal funding for important public health priorities, including Community Health Centers, the Special Diabetes Programs, the National Health Service Corps, Teaching Health Center Graduate Medical Education, Family-to-Family Health Information Centers, the Youth Empowerment Program, and the Personal Responsibility Education Program.

Extension for Community Health Centers and the National Health Service Corps

Federally Qualified Health Centers (FQHCs) are community-based, patient-centered organizations that provide comprehensive health services to medically underserved populations. The Health Resources and Services Administration's (HRSA) Health Center Program, authorized under Section 330 of the Public Health Service Act, awards grants to these outpatient clinics in order to enhance the provision of medical, dental, mental health and other primary care services. These Section 330 grants are used for broad purposes – such as expanding health services, supporting new health centers, hiring more staff, and maintaining/improving facilities. Grant funds are also used to provide care to uninsured patients. As a condition of receiving a Section 330 grant, a health center is required to provide care to the entire population of their designated service area, regardless of an individuals' ability to pay, through sliding-scale fees determined by income and family size.

Since the 1970s, the National Health Service Corps (NHSC) has helped address the primary health care shortage in underserved communities by helping them to recruit and retain qualified health practitioners. Currently, 10,400 NHSC members provide care to more than 11 million people in the country, regardless of their ability to pay. In exchange for a commitment to work in a Health Professional Shortage Area (HPSA), the program provides scholarships to students training in primary care to cover tuition, fees, other educational costs, and student loan repayments of up to $50,000 a year to primary care and mental health clinicians. To receive a scholarship, a student must agree to two to four years of service in an NHSC-approved site in a HPSA. Loan repayments are for primary care, dental, and mental health clinicians who agree to at least two years of service in an NHSC-approved site in a HPSA. The intent is to encourage Corps members to remain in underserved communities after their service commitment has ended.

The legislation extends the funding for Community Health Centers and the NHSC for two years, at $3.6 billion a year for Community Health Centers, and $310 million a year for the NHSC. In addition, Section 101 includes several technical and programmatic changes that improve the health centers' ability to function in the modern health care landscape. Specifically, this section:

- Updates the statute for the Health Centers Program to reflect the terminology of the Comprehensive Addiction and Recovery Act by changing the terminology from "Substance Abuse" to "Substance Use Disorder."
- Provides the HRSA with explicit authority to make supplemental awards to Health Centers focused on quality improvement.
- Gives HRSA explicit authority to make grants for New Access Points and Expanded Services, clarifying the focus on unmet need, and extends the current rural to urban statutory ratio guardrails for New Access Points and Expanded Services.
- Adds homeless veterans and veterans at risk of homelessness to the list of focus populations for grants focused on care to the homeless.
- Requires health centers to consult and collaborate with existing local providers, programs and agencies with respect to the services and programs offered by a new site.

- Provides the legal authority for HRSA to require direct employment of health center Chief Executive Officers and Executive Directors, ultimately protecting the autonomy and integrity of the health center program.
- Requires health centers to have written policies and procedures around appropriate use of federal funds to ensure that the center is operated in compliance with applicable federal laws and regulations.

Extension of the Special Diabetes Program

The legislation extends the funding for two years the Special Diabetes Program for Type 1 Diabetes and the Special Diabetes Program for Indians at $150 million a year each. The Special Diabetes Program for Type 1 Diabetes, administered by the National Institute of Diabetes and Digestive and Kidney Diseases in collaboration with multiple institutes at the National Institutes of Health and the Centers for Disease Control and Prevention, supports research on the prevention and cure for type 1 diabetes. The Special Diabetes Program for Indians, coordinated by Indian Health Service (IHS) Division of Diabetes with guidance from the Tribal Leaders Diabetes Committee, funds for diabetes treatment and prevention to IHS, Tribal, and Urban Indian health programs across the country.

Reauthorization of program of payments to Teaching Health Centers that operate Graduate Medical Education programs

The legislation extends the funding for the Teaching Health Center Graduate Medical Education (THCGME) Program for two years, at $126.5 million a year. According to the Government Accountability Office (GAO), Medicare accounts for 85 percent of funding for graduate medical education. Medicaid, the HRSA, the Department of Veterans Affairs, and the Department of Defense support the remaining 15 percent of GME. Because residency training has traditionally been hospital-based under the THCGME program, HRSA provides payments to outpatient facilities, such as community health centers, to support training in primary care for medical and dental residents.

Extension for Family-to-Family Health Information Centers

The legislation extends the Family-to-Family Health Information Center program for two years at $6 million a year. The Family-to-Family Health Information Centers are family-staffed and family-run centers in the 50 states and the District of Columbia that provide information, education, technical assistance, and peer support to families of children with special health care needs and health professionals who serve those families. In addition to extending the funding, this Section also establishes Family-to-Family Health Information Centers in all of the territories and for the Indian tribes.

Reauthorization of the Youth Empowerment Program and the Personal Responsibility Education Program

Abstinence Education Grants are formula grants available to states that request funding when applying for Maternal and Child Health Block Grant funding. In addition to making

significant programmatic reforms, the legislation changes the name of the program from Abstinence Education to the Youth Empowerment Program, reflecting the intent of the program to empower youth to make healthy decisions, resist sexual risk, and set goals for the future. It provides $75 million for each of FY 2018 and 2019 to be granted to the States for sexual risk avoidance education. Similar to the Personal Responsibility Education Program (PREP), if a State does not apply for grant funding, the Secretary shall allot to one or more entities in the State, through a competitive grant process, the amount that would have been allocated to the State had it applied for the funding. A State or entity that receives funding must collect information on the programs and activities funded through its allotment and submit a report to the Secretary on the data from such programs and activities. In consultation with relevant stakeholders, the Secretary must establish and conduct one or more national evaluations of the education funded through the Youth Empowerment Program and submit a report to Congress on the information collected and the program outcomes.

The legislation also provides $75 million for each of FY 2018 and 2019 for the Personal Responsibility Education Program (PREP). PREP is primarily a state formula grant program to support evidence-based programs designed to educate adolescents about abstinence, contraception, and adulthood. PREP contains five components: (1) state PREP formula grants; (2) competitive state PREP grants; (3) tribal PREP grants; (4) PREP Innovative Strategies grants; and (5) funding for training, technical assistance, and evaluation.

Providing for Qualified Health Plan grace period requirements for issuer receipt of advance payments of cost-sharing reductions and premium tax credits that are more consistent with State law grace period requirements

Under current law, subsidized patients with exchange plans have a three-month grace period when they do not pay their health insurance premiums. During these three months, their plan cannot discontinue coverage for nonpayment of premiums. This means that patients receiving the advance premium tax credits (APTCs) and cost sharing reductions (CSRs) can pay for only nine months of health insurance, but receive a full year's coverage. According to one McKinsey report, one-in-five exchange enrollees stopped payment in 2015 with nearly 90 percent of these individuals repurchasing a plan the following year. Of this group, half enrolled in the same plan they stopped payment for in 2015. The legislation allows states to define their grace period, or move to a default of one month.

Reduction of the Prevention and Public Health Fund

The legislation cuts $6.35 billion from Prevention and Public Health Fund (PPHF) over ten years. The Patient Protection and Affordable Care Act established the PPHF as an advanced appropriation for prevention, wellness, and public health initiatives to be administered Department of Health and Human Services (HHS). Annual appropriations for the PPHF continue in perpetuity. If Congress does not explicitly allocate the funding, the HHS Secretary has broad authority to spend these dollars without Congressional oversight.

C. H.R. 1148, The Furthering Access to Stroke Telemedicine (FAST) Act of 2017

The Committee will consider H.R. 1148, as amended by the subcommittee on Health, introduced by Rep. Griffith (R-VA) and Rep. Beatty (D-OH), which would expand the ability of patients presenting at hospitals or at mobile stroke units to receive a Medicare reimbursed neurological consult via telemedicine. Currently, Medicare will only pay for such a consultation if the originating site hospital is in a rural Health Professional Shortage Area or a county outside a Metropolitan Statistical Area. However, 94 percent of stroke patients live in urban and suburban areas. Stroke is currently the 5th leading cause of death and is projected to increase significantly; associated costs are projected to triple by 2030. However, with quick treatment, stroke patients can mitigate subsequent medical complications and disability, but every minute can count. The legislation will increase timely access to trained neurologists through telemedicine in the Medicare program so they can direct patient care at the earliest possible intervention point. H.R. 1148 passed the Health Subcommittee on a voice vote.

D. H.R. 2465, The Steve Gleason Enduring Voices Act of 2017

H.R. 2465, introduced by Rep. McMorris Rogers (R-WA), Rep. Scalise (R-LA), and Rep. Larson (D-CT), would make coverage of speech generating devices under "routinely purchased durable medical equipment" permanent under the Medicare program. Previously, under rules issued by CMS, speech generating devices, which are uniquely configured for each eligible beneficiary, were categorized and covered under a capped rental payment. However, if the beneficiary entered a nursing home, hospital, or hospice, payment ended, which limited access to the device. Congress responded in 2015 by passing the Steve Gleason Act, which removed speech generating devices from the capped rental categorization. The bill would remove the 2018 sunset and make this payment category change permanent. H.R. 2465 passed the Health Subcommittee on a voice vote.

E. H.R. 2557, The Prostate Cancer Misdiagnosis Elimination Act of 2017

The Committee will consider an amendment in the nature of a substitute to H.R. 2557, introduced by Rep. Bucshon (R-IN) and Rep. Rush (D-IL). The bill would provide for coverage of DNA Specimen Provenance Assay (DPSA) testing. Prostate cancer is diagnosed with a 10 to 12 needle biopsy samples to detect for cancerous cells, a protocol that became the clinical standard in 2010 and improved the detection rates of prostate cancer. However, despite rigorous lab protocols, a high rate (2.5 percent) of specimen provenance complications (SPCs) occur, where a test result is contaminated with tissue other than the patient's. As a result, approximately 1.28 percent of positive tests are in fact cancer free. DPSA is a diagnostic tool that can address the chances of a false diagnosis, preventing unnecessary and costly treatment protocols. DPSA compares the DNA of the patient to the DNA of the tissue sample tested for cancer. Currently, this test is not covered under the Medicare payment program due to its classification as "quality assurance" rather than a diagnostic test. The amendment will clarify payment rates, set reporting standards and establish a reasonable implementation schedule. H.R. 2557, as introduced, passed the Health Subcommittee on a voice vote.

F. H.R. 3120, to reduce the volume of future electronic health record-related significant hardship requests

H.R. 3120, sponsored by Rep. Burgess (R-TX) and Rep. Dingell (D-MI), amends the Health Information Technology for Economic and Clinical Health (HITECH) Act in order to remove a requirement that requires the Secretary of Health and Human Services (HHS) to continue to make meaningful use standards more stringent over time. While the meaningful use program has been very successful in driving adoption of electronic health records (EHRs), many providers have struggled to meet the requirements of meaningful use. As the Secretary is mandated to continue to raise the standards overtime, more and more providers are likely to fall behind. When this happens, providers will often seek a hardship waiver to acknowledge they could not meet the increased standards. This increases the burden further on HHS to process an ever increasing number of hardship requests. The bill simply removes the mandate that meaningful use standards become more stringent over time and allows the Department to be more deliberative in such evaluations. H.R. 3120 passed the Health Subcommittee on a voice vote.

G. H.R. 3245, The Medicare Civil and Criminal Penalties Act

H.R. 3245, introduced by Rep. Bilirakis (R-FL) and Rep. Castor (D-FL), would update both civil and criminal penalties in the Medicare program. Many of these penalties were last updated 20 years ago. H.R.3245 passed the Health Subcommittee on a voice vote.

H. H.R. 3263, to extend the Medicare Independence at Home Medical Practice Demonstration program

H.R. 3263, sponsored by Rep. Burgess (R-TX) and Rep. Dingell (D- MI), would extend the Independence at Home Medical Practice Demonstration Program (IAH), which provides a home-based primary care benefit to high-need Medicare beneficiaries with multiple chronic conditions, allowing them to avoid unnecessary hospitalizations, ER visits, and nursing home use, for two additional years. Currently in its fifth year, CMS has evaluated the program's success and found it to have saved money for the program in the first and second years (year 3 data is still being analyzed.) Under statute, the demonstration in total must generate savings, and any practice that does not generate savings of 5 percent faces removal from the demonstration. This extension will provide CMS with additional time to evaluate the program's effectiveness and any changes that may be needed so that Congress can weigh the benefits of the demonstration to program savings and beneficiary care and whether the program should be changed, extended, or made permanent. The Committee will consider a bipartisan technical amendment to the bill, after consultation with CMS, to ensure proper implementation of the policy.

I. H.R. 3271, The Protecting Access to Diabetes Supplies Act of 2017

H.R. 3271, introduced by Rep. DeGette (D-CO) and Rep. Brooks (R-IN), addresses several issues beneficiaries face under the competitive bidding program regarding Diabetes Test Strips (DTS). Many of these issues stem from how CMS has enforced certain beneficiary protections. The competitive bidding program has several beneficiary protections that the legislation seeks to place into statute to ensure proper oversight and enforcement of these protections. For example, evidence has been presented that the 50 Percent Rule – established by

Congress to ensure suppliers make available at least 50 percent of all types of DTS on the market before enactment of the competitive bidding program – has not been fully enforced by CMS. The legislation would codify these protections and provide enhanced reporting that will aid Congress and CMS in ensuring beneficiaries are receiving the diabetic testing supplies they need to manage their condition. H.R. 3271 passed the Health Subcommittee on a voice vote.

J. H.R. 849, The Protecting Seniors' Access to Medicare Act of 2017

This legislation, introduced by Rep. Roe (R-TN) and Rep. Ruiz (D-CA), would repeal the Independent Payment Advisory Board (IPAB). The IPAB is a panel created by sections 3403 and 10320 of the Patient Protection and Affordable Care Act to recommend policies to reduce growth in Medicare spending if certain growth targets are exceeded. The IPAB is triggered when the growth rate in Medicare exceeds target growth rates, as reported by the CMS Office of the Actuary, and is responsible for recommending to Congress spending reductions in the Medicare program in order to reduce the growth of the program below the target growth rate. Because no members of the IPAB have been appointed, if the IPAB is triggered, the policies to achieve reductions in Medicare to meet target growth rates would be recommended and implemented by the Secretary for Health and Human Services.

III. STAFF CONTACTS

If you have any questions regarding this markup, please contact Paul Edattel, Josh Trent, James Paluskiewicz, Kristen Shatynski, Caleb Graff, or Adam Buckalew of the Committee staff at (202) 225-2927.